

ANGLIA RUSKIN UNIVERSITY
THE THEATRE OF WAR, THE DRAMA OF LIFE

COMBAT VETERANS' PERSPECTIVES ON A DRAMATHERAPY JOURNEY
A PHENOMENOLOGICAL MIXED METHODS CASE STUDY

LINDA C. WINN

A thesis submitted in partial fulfilment of the requirements of Anglia Ruskin
University
for the degree of Doctor of Philosophy

Submitted 2016

Acknowledgements

Very many thanks go to Dr Ditty Dokter and Professor Helen Odell-Miller. Without their support, encouragement and wise counsel I would have abandoned this journey when the storm-winds blew.

I am indebted to my family and friends for their love and kindness when I have been preoccupied with my research. There have been many times during this period we have laughed together and cried together. We have celebrated new life and had to say goodbye too soon to others. I thank my grandchildren for being there to bring me back to earth.

There have been many people who have assisted me since the 1980s when I began working with veterans. I feel truly blessed and want to thank them all, unfortunately space and word limits preclude that. I shall just name a few: Surgeon Captain Morgan O'Connell, RN, for inviting me on to the PTSD course at Royal Naval Hospital Haslar, and his support and humour over the years; Alida Gersie for her initial generosity of time and recommendation that set me on this path; Sue Jennings for her interest, enthusiasm and willingness to share her knowledge; Kim Dent-Brown for making figures appear easy; Di Gammage for her thoughtful clinical supervision; my friends in our Action Learning Set, all proving life-long learning can be fun; Janey Fisher who has only joined me in recent months but whose copyediting skills and proof-reading was always good humoured and kept me on course for this last stretch of the journey. I thank Faber and Faber and Simon Armitage for permission to use extracts from his version of *Homer's Odyssey* (2010), the text that became our guidebook.

There are three people, combat veterans, without whom this study would not have happened: Alan, Jack and Chris (participant chosen pseudonyms). I thank them beyond measure for trusting me enough to embark on this journey with me. At times we made new discoveries, at others there were storm clouds on the horizon, but they all held fast, looking out for one another. They shared generously both time and their stories as we travelled together. Their motivation was to discover whether other veterans suffering from the effects of trauma or having difficulty *returning home*, could be helped through dramatherapy. I hope I have achieved my aim of ensuring their voices are heard clearly throughout this research.

I am honoured to be able to do this work with veterans and families and thank others I have met along the way and have taught me so much. My research is dedicated to the memory of those whose journey in this life is over. May they find peace and those they leave behind be comforted as they travel on, buoyed by courage, hope and love.

Linda C. Winn August 2016

Abstract

THE THEATRE OF WAR, THE DRAMA OF LIFE

COMBAT VETERANS' PERSPECTIVES ON A DRAMATHERAPY JOURNEY

A PHENOMENOLOGICAL MIXED METHODS CASE STUDY

LINDA C. WINN

AUGUST 2016

A review of academic literature revealed a dearth of published research concerning whether dramatherapy might help UK combat veterans recover from Post Traumatic Stress Disorder (PTSD). Furthermore no published research sought to capture veterans' perspectives during dramatherapy in the UK.

My research questions addressed the gap in the research literature: What is the participant's perspective on the use of dramatherapy in helping British combat veterans a) to recover from PTSD? and b) to adjust to civilian life?

The research design was a phenomenological mixed methods case study. The qualitative measures were arts-based. Interpretative Phenomenological Analysis (IPA) was used to examine the transcripts of the dramatherapy sessions. The quantitative measures were the Clinical Outcomes Routine Evaluation (CORE) -34 and CORE-10; Short Warwick Edinburgh Mental Well-being Scale (SWEMWBS) and the PTSD Checklist – Military (PCL-M). The multiple methods synthesis raised questions and gave new insights rather than confirming results.

The participants were 3 male veterans from the same region of the UK. I was the researcher/dramatherapist. The aim of the research was to achieve an in-depth study underpinned by a participant-centred approach.

The research theme was journeying towards recovery. The choice of play-text, an excerpt from *The Odyssey*, reflected this.

The initial 5 dramatherapy sessions were individual and the remaining 3 were group sessions. The IPA indicated that the participants' perspectives were that dramatherapy might help other veterans towards recovery from PTS. Furthermore dramatherapy might help in their adjustment to civilian life. The use of , imagination and role rehearsal and assisted in reframing of their personal stories. The participants found the use of a novel method developed by myself, from Turner's Model of Crisis (TMOC) (Turner, 1967) particularly helpful in moving through traumatic memories, utilising metaphor and a problem-solving approach. This led to embodiment of reprised positive military roles in overcoming obstacles on their journeys. They used this method in other situations arising outside of the research and recommended it as potentially having a positive impact on other veterans, seeking recovery.

They remained in the clinically significant scoring for PTSD. However, they identified the framework of dramatherapy methods resulted in an increase in confidence, creativity and ability to manage conflict. This was supported by the IPA results.

Key words: veteran, PTSD, dramatherapy, IPA, mixed methods, embodiment, metaphor, role

Table of Contents

List of diagrams and tables	viii
List of appendices	xi
Copyright	xii
 Chapter 1 Where shall we go? Thesis Introduction and Overview	
1.1 Introduction	1
1.2 The context of the research	2
1.3 The type of study	3
1.4 The focus for this study	4
1.5 The research questions	4
1.6 The purpose of the study	5
1.7 Operational definitions and key terms	6
1.8 Significance of the study	7
1.9 Delimiters and limitations	8
1.10 My personal journey to the start of this study	10
1.11 Summary	11
 Chapter 2 Mapping the Territory	
2.1 Introduction	13
2.2 The literature review	13
2.3 Military mental health	15
2.4 PTSD diagnosis and treatment recommendations	18
2.5 Arts therapies, combat and trauma	19
2.6 Conclusion	30
 Chapter 3 The guidebook: Research Methods and Study Design	
3.1 Introduction	33
3.2 The research questions	33
3.3 The study design	34
3.4 The context	42
3.5 Participant selection	43
3.6 Data collection	44

3.7 The rationale for the Interpretative Phenomenological Analysis (IPA)	48
3.8 Ethics and consent	52
3.9 Summary	53
 Chapter 4 Tools for the journey: Dramatherapy Methods	
4.1 Introduction	54
4.2 The participants	54
4.3 Treatment structure and clinical rationale	55
4.4 Key dramatherapy procedures	58
4.5 Summary	66
 Chapter 5 Signposts: Analysis and Interpretation of the Evidence	
5.1 Introduction	67
5.2 Qualitative data results	68
5.3 IPA	72
5.4 Quantitative data results	135
5.5 Overview of findings	142
 Chapter 6 The scenery: Synthesis of Findings	
6.1 Introduction	145
6.2 What is the participant's perspective on the use of dramatherapy in helping British combat veterans to recover from PTSD?	145
6.3 What is the participant's perspective on the use of dramatherapy in helping veterans to adjust to civilian life?	154
6.4 The veterans' perceptions of the usefulness of dramatherapy methods	163
6.5 Participants' perspectives on hindering aspects of dramatherapy	170
6.6 Unexpected findings	171
6.7 Summary of results	175
 Chapter 7 Homeward bound: Summary of the Study	
7.1 Answering the research questions	177

7.2 The contribution to knowledge	181
7.3 Critique of the methodology	185
7.4 Limitations of the study	192
7.5 Recommendations for clinical practice	194
7.6 Recommendations for further research	195
7.7 Personal reflections	196
7.8 The end of the journey ...	201
References	202
Appendices	241

List of Diagrams, Figures and Tables

Diagrams and figures

Figure 2.1 Therapeutic elements of Creative Arts Therapies and CBT	20
Figure 2.2 Art psychotherapy levels of evidence	21
Figure 2.3 Johnson, Landy and Winn's modes of working with psychological trauma	28
Figure 3.1 Five misunderstandings about case study research	40
Figure 3.2 Research question pathway	41
Figure 3.3 SWEMWBS scoring guide	46
Figure 4.1 Participant details	54
Figure 4.2 6PSM	58
Figure 4.3 BASIC Ph assessment scale	59
Figure 4.4 6PSM: The seven levels of assessment	60
Figure 4.5 Examples of communiwells created by the participants	61
Figure 4.6 Diagrammatic form of Turner's Model of Crisis	62
Figure 5.1 Alan's scoring on 6PSM	69
Figure 5.2 Jack's scoring on 6PSM	70
Figure 5.3 Chris's scoring on 6PSM	71
Figure 5.4 A comparison of all participant' scores - BASIC Ph Sessions 1 and 8	72
Figure 5.5 Superordinate themes and subordinate themes	73

Figure 5.6 EPR Jennings (2012 pp. 180-182) applied to IPA findings	101
Figure 5.7 Key aspects from dramatherapy sessions revealed by IPA	135
Figure 5.8 CORE-34 test results for Alan	136
Figure 5.9 CORE-10 test results for Alan	136
Figure 5.10 SWEMWBS test results for Alan	137
Figure 5.11 PCL-M test results for Alan	137
Figure 5.12 CORE-34 test results for Jack	138
Figure 5.13 CORE-10 test results for Jack	138
Figure 5.14 SWEMWBS test results for Jack	139
Figure 5.15 PCL-M test results for Jack	139
Figure 5.16 CORE-34 test results for Chris	140
Figure 5.17 CORE-10 test results for Chris	140
Figure 5.18 SWEMWBS test results for Chris	141
Figure 5.19 PCL-M test results for Chris	141
Figure 6.1 Factors identified as assisting in recovery from trauma including session involved	146
Figure 6.2 Key to session numbers	146
Figure 6.3 Turning points and transformation	151
Figure 6.4 The veterans' perspectives of dramatherapy contributing to adjustment to civilian life	155

Figure 6.5 The main dramatherapy methods	163
Figure 6.6 Factors contributing to the veterans' perceptions of the useful and hindering aspects of dramatherapy	164
Figure 7.1 Y-model for clinician/researcher	199

List of Appendices

Appendix 1 <i>Homer's Odyssey</i> extracts	239
Appendix 2 British armed conflicts and wars (1914–2014)	
Historical and psychological context.	262
Appendix 3 Study recruitment poster	273
Appendix 4 Specimen copies of outcome measures	274
Appendix 5 Anglia Ruskin University Research Ethics Committee Permission	280
Appendix 6 Sample information and consent sheets	281
Appendix 7 Copies of Alan's, Jack's and Chris's 6PSM	290
Appendix 8 Samples of the emerging theme tables, colour coding and mindmaps	292
Appendix 9 Sample transcripts and data from an IPA analysis	299
Appendix 10 Personal communication from Jonathan A Smith, 4th April 2015	300
Appendix 11 IPA audit report	301
Appendix 12 Participants' prose and poems	305

Copyright declaration (iv)

Attention is drawn to the fact that copyright of this thesis rests with:

Linda C. Winn

This copy of the thesis has been supplied on condition that anyone who consults it is bound by copyright.

Chapter 1 Where shall we go? Thesis Introduction and Overview

1.1 Introduction

This study examined whether dramatherapy might contribute to combat veterans (veterans) recovery from psychological trauma. In particular, it explored the participants' perspectives on the use of dramatherapy in helping British veterans a) to recover from Post Traumatic Stress Disorder (PTSD)? and b) to adjust to civilian life?

Individual clinical results derived from dramatherapy with combat veterans since the 1980s suggest the veterans experienced the interventions as helpful (Winn, 2011). However this reporting remained anecdotal and my earlier research on dramatherapy and PTSD did not focus on a particular client group (Winn, 1994, 1998). Dramatherapy research on PTSD has expanded in the last 20 years (Lahad, 1995; James et al., 1996; Johnson et al., 1996; Johnson et al., 2004; Johnson, 2009a; Lahad and Doron, 2010; Lahad et al. 2010; Lahad et al., 2013; Sajnani and Johnson, 2014).

In this chapter I discuss the contextual background for the study before giving the statement of the problem (1.2) and the type and focus of the study (1.3, 1.4). In sections 1.5–1.6 I set out the research questions and the objectives, the purpose and scope of the study and the conceptual framework. I then deal with operational definitions, key terms (1.7) and explain the significance (1.8) and the delimiters and limitations of the study (1.9). Finally there is a section on my personal journey to this study (1.10) and a summary linking the different sections (1.11).

Chapter 2 introduces the literature underpinning this research. There are subsections on psychological trauma, historical and literature perspectives on warriors returning from battle, dramatherapy, adjustment and recovery, particularly relating to studies involving veterans.

Chapter 3 describes the research design, the recruitment of participants, assessment process and scales, reflecting the Mixed Methods approach in a combination of arts based and universal measures.

Chapter 4 introduces the fieldwork, describing the participants, the clinical methods and rationale, and key dramatherapy methods.

Chapter 5 sets out the qualitative and quantitative results and describes the dramatherapy research sessions in detail with representative examples from the IPA.

Chapter 6 synthesises and discusses the results in relation to the research questions.

Chapter 7 draws inferences from the study results, and reviews the conceptual framework, study limitations, and personal reflections.

1.2 The context of the research

Military personnel exposed to the trauma of war may experience severe psychological difficulties when adjusting to life as a civilian. It could be that what has been experienced, whether in childhood and/or combat, has contributed to psychological difficulties. This might manifest in a variety of ways. The most common diagnosis for combat veterans with psychological difficulties is that of Adjustment Disorder, with PTSD coming further down the list after alcohol misuse, depression and personality disorder (Rona et al., 2009). My study acknowledged the potential for other psychological diagnoses to be present, through the choice of wording *affected by trauma*.

Psychological trauma – the trajectory

Combat trauma was recognized as long ago as the Hellenic era (Meagher, 2006) when Heracles, the divine hero, returns from the hell of war, continuing in his own living hell and madness, he murders his wife and three children in a fugue state (Barglow, 2013). It is of note though that whilst traumatic responses are described not only in Greek tragedies but also in Shakespeare and Dickens, internet searches for tales of traumatic reactions do not come to the fore until the American Civil War and then World War I (WWI). In WWI expressions of fear or avoidance of battle led to incarceration or being shot as a traitor. In ancient times giving any sign of being scared made one easy prey to the enemy.

During WWI what is now called Combat Related PTSD was termed ‘shellshock’ (Myers, 1916). In 1940 Myers stated that he had not invented the term, although he has been credited with doing so (E. Jones and Wessely, 2005a.; Sheehan et al., 2009).

William Rivers, who had a background in social anthropology in addition to being a doctor of medicine, favoured a talking treatment for patients he saw at Craiglockhart Hospital in

Edinburgh. Although Freud's teaching influenced him, it is thought that his approach would now be considered a form of Cognitive Behaviour Therapy (CBT) (Webb, 2006; McKenzie, 2012). He was not convinced that one type of treatment suited everyone (Rivers, 1918). He was at odds with his colleague Yealland who took the view that those exhibiting shell shock lacked moral fibre (LMF) and needed to be punished, until convinced that they should do the right thing and return to battle (Adrian and Yealland, 1917; Yealland, 1923). Yealland was one of the first medics to use electrical treatment to aid recovery (Linden, Jones and Lees, 2013). There was a social influence on the recognition and treatment of shellshock. It was regarded widely as malingering, hysterical, cowardice, and dangerous to the morale of the fighting forces. This might now be regarded as an embarrassing time in the history of military medicine, however much can be learnt if we pay attention to the historical pathway of treatment of combat-related trauma.

Veterans

At the time of my study the UK Government definition of a veteran is someone who has served at least one day in the UK armed forces. This definition has taken into account the views of various UK-based veteran groups and has sought to be an inclusive, encompassing definition (Dandeker et al., 2006). The participants involved in this research were all engaged in active combat during service.

1.3 The type of study

The research was clinical practice based. It studied, in depth, the use of dramatherapy in the assessment and treatment of 3 male adult individuals who had been diagnosed as suffering from complex PTSD. Individual and group dramatherapy sessions were used and these are detailed in Chapter 4.

Mixed Methods

The choice of a phenomenological mixed methods case study was influenced by my wish to provide a voice for the veterans. The use of Interpretative Phenomenological Analysis (IPA) (J.A. Smith, Flowers and Larkin, 2009) ensured that the data was rich and multi-faceted. It allowed for the emergence of novel themes. The use of validated self-report outcome scales, widely used in UK clinical settings, aimed to make the results more accessible to practitioners from other clinical backgrounds. It also reflected my clinical

practice, where I find the measures can be of benefit to the clients in demonstrating how they are progressing in therapy. The convergent parallel mixed methods study provided richer information to address the research questions than a single method would do (Olsen, 2004; Creswell and Piano Clark, 2011).

Themes

Veterans seeking a path to recovery often speak of feeling as though they have not returned home (Shay, 2002; Sherman, 2007). Some of the dramatherapy clinical methods I use involve creating a journey (Gersie, 1991, 1996; Winn, 1998) other therapists have used this theme as a foundation for treatment (Shay, 2010; Morie, Haynes and Chance, 2011). The exploration of the meaning found by the veterans in their dramatherapy journey towards recovery led to my decision to select the play text extract from an adaption of Homer's *Odyssey* (Armitage, 2010; see Appendix 1).

1.4 The focus for this study

Some veterans suffering from Post Traumatic Stress (PTS) report an increased sense of well being when engaged in dramatherapy (Winn, 2013; James et al., 1996). Various descriptive studies reflect good outcomes but these studies have lacked robust data within the current field of trauma treatment (Dokter and Winn, 2009; Foa et al., 2009). A literature search of dramatherapy in the UK revealed no records of research on the use of dramatherapy in the treatment of combat veterans, which sought to capture the veteran's perspective on whether it is useful or a hindrance to recovery or adjustment to civilian life. It was necessary to extend the literature review to the United States (US) where Johnson had pioneered dramatherapy with veterans (Johnson et al., 1996).

1.5 The research question

My research questions addressed the gap in the research literature referred to in 1.1 above: What is the participant's perspective on the use of dramatherapy in helping British combat veterans a) to recover from PTSD? and b) to adjust to civilian life?

1.6 The purpose of the study

This study examined whether, from the veteran's perspective dramatherapy methods might contribute to recovery from PTSD and adjustment to civilian life. Returning warriors have often found it difficult to adjust to a different 'civilian' culture. They may seek new or reprised roles (Landy, 1993). Dramatherapy methods developed in the US Veterans' Affairs (VA) centers might inform treatment in the UK (James et al., 1996; Johnson et al., 2004). Lahad does not work directly with veterans, his experience researching and treating and preventing PTSD, in children and families internationally, provides further potential for developing responses to PTS in UK veterans. Dramatherapy might be particularly useful in terms of the Embodiment, Projection, Role Paradigm originally devised based on developmental theory for children under seven years old (Jennings, 1992). It is now proving useful for those who have had their sense of attachment disrupted by trauma and those unable to have experienced developmental pathways due to traumatic events in childhood (Jennings, 2004). The study examined whether the participants thought this model could be helpful to -veterans.

Whilst in the military most veterans displayed physical and psychological tenacity. They also had to enact new roles, such as warrior, leader, peacekeeper, ceremonial and those specific to their particular area of service. The roles would be built and rehearsed so that a level of competency was acquired. Components of these aspects may be re-engaged to overcome current difficulties. In earlier research, based on Victor Turner's Model of Crisis (TMOC) (Turner and Schechner, 1988; Figure 4.6) it became clear that veterans were able to utilise some skills that they had used in service (Winn, 1998). Phrases such as 'planning the campaign,' '[drill] rehearsal' 'theatre [of war]', 'company' resonate with the military mind. These terms are similar to theatre performance terms. Veterans appeared able to work with familiar strategies to enhance resilience.

They offered insights and perspectives derived from their personal and group perspectives. Too often they have experienced not being listened to, so paying attention to this, can I think, increase the opportunity for the healing of wounds and illuminate practice they found useful and conversely that which may have a detrimental effect.

1.7 Operational definitions and key terms

Dramatherapy

The UK professional registration body, the Health and Care Professions Council (HCPC) defines dramatherapy as: ‘... a unique form of psychotherapy in which creativity, play, movement, voice, storytelling, dramatisation, and the performance arts have a central position within the therapeutic relationship’ (Health and Care Professions Council, 2013). The British Association of Dramatherapists (BADth) states:

Dramatherapy is a form of psychological therapy in which all of the performance arts are utilized within the therapeutic relationship. Dramatherapists are both artists and clinicians and draw on their trainings in theatre/drama and therapy to create methods to engage clients in effecting psychological, emotional and social changes. The therapy gives equal validity to body and mind within the dramatic context; stories, myths, play texts, puppetry, masks and improvisation are examples of the range of artistic interventions a Dramatherapist may employ. These will enable the client to explore difficult and painful life experiences through an indirect approach (www.badth.org.uk).

PTSD

The definition of PTSD was first formally listed in the Diagnostic Statistical Manual DSM-III (American Psychiatric Association, 1980), where it is classed as an anxiety disorder. Over the timespan of this study the classification for PTSD was from DSM-IV-TR (American Psychiatric Association, 2000). The formal diagnosis is classified as PTSD, however there is a movement to refer to PTS rather than terming it as a disorder. It is argued that to classify PTS as a disorder risks stigmatising something that is considered a normal reaction to an event outside normal human experience (M. Fisher and Schell, 2013). There is concern that PTS may be used to include those who do not fulfil the criteria for PTSD. I used both terms within my research as a reflection of the literature and veterans’ preference.

Participant; expert patient; client or pseudonym

In the UK the patient is now acknowledged as an expert in their experience of their illness or condition (Tyreman, 2005; Warne and McAndrew, 2007). This places their views of useful or hindering aspects of services and treatment as a core element of health services and interventions. There is a view that the term *expert patient* or *expert by experience* may not be helpful as it adds another label to the individual (Wilson, Kendall and Brooks, 2007; Warne and McAndrew, 2007; McLaughlin, 2009). In the UK the alternative term client is often used to denote independence and choice. Interestingly the term *expert client* is not used. When referring to clinical practice within the study, unrelated to the research data I use the term client/s. However McLaughlin (2009) suggests the term denotes a power imbalance and a paternalistic approach. In my clinical practice I always ask the person what they prefer to be called. My view is that the study participants were equal as unique individuals. They provided a perspective from their experiences, which was central to the research. I chose instead to refer to them by name (even though they are pseudonyms for ethical purposes). This follows the recommendations of IPA where to emphasise individuality pseudonyms for participants are preferred to letters or numbers (Smith, Larkin and Flowers, 2009). At other times for clarification and following academic research protocol they are referred to as participants.

1.8 Significance of the study

Two leading post-doctoral researchers, dramatherapists and clinical psychologists, Johnson and Lahad, have published widely in the particular field of combat and trauma. Johnson has worked with veterans for many years and concentrates on interpersonal growth (Sajnani and Johnson, 2014; Johnson, 2010; Johnson et al., 1996). Lahad specialises in resilience in children and community led responses to trauma. He has also developed SEE FAR CBT as an intervention for trauma sufferers and workers (Lahad and Doron, 2010). Landy (1993) devised the role taxonomy, which identifies the warrior and soldier characters amongst his role repertoire. My study aimed to build on that knowledge base with a particular focus on adjustment and recovery. P. Jones (2009) reminds us of the need for pluralistic research, which places the client/s at the centre, giving prominence to their perceptions. This influenced my choice to put the veterans' perspectives of dramatherapy as central to the study.

Dramatherapy methods and the associated treatment structure (outlined in Chapter 4) provided a framework for treatment in this study. Treatment frameworks can act as a safe container for participant/s and therapist (Gersie and King, 1990; Winn, 1994; Dokter, 2011). In terms of funding for treatment, a framework, stipulating the outline of dramatherapy sessions, care pathway and aims, increases the confidence of the service purchaser.

A counter-argument to this is that dramatherapy has as its essence creativity and an emphasis on going with the process (Johnson, 2000). If the framework can be thought of as a map for the journey with guidebooks, to inform, not to obstruct, then it could be that the structure provides footholds for the journey.

1.9 Delimiters and Limitations

The delimiters and limitations of this study are discussed fully in the final chapter as part of the critique of the methodology. To assist the reader, briefly the following applied:

Delimiters

I implemented the dramatherapy interventions as a participant observer (Thomas, 2010). Advances in neurobiology and trauma (van der Kolk, 2006; Dolan et al., 2012; P.A. Levine, 1997) have discovered that the limbic system of the brain is not amenable to cognitive approaches. The emotion of trauma remains stored in the somatic system. Investigation into the neurobiological changes, which might occur during dramatherapy, was beyond the scope of this study.

Limitations

The researcher/dramatherapist

My study specified particular interventions; however the therapist effect has to be taken into account and the individual variable of the clients. My way of working as a dramatherapist is person-centred, putting at the heart of therapy, the individual and their needs (Mearns and Thorne, 2000). Manualised treatment cannot replace therapist skills, experience with the particular problems and interventions, and the building of trust and a therapeutic alliance with the treatment recipient (Heron, 2001a). A balanced view of the ‘individual therapist effect’ and technical proficiency is offered by Lambert (2013) who

highlights the risk of applying a formulaic approach in therapy. The potential positive bias of my interpretations was reduced by the use of member checking (Larkin and Thompson, 2012) and an external audit of the IPA (J.A. Smith, Flowers and Larkin, 2009). Further consideration is given to the therapist influence in Chapter 3, 6 and 7.

Prior knowledge of the study participants

The study participants knew me from a local veterans' support hub. The geographical area and small number of practitioners working with the veteran population, meant that many knew me. I had worked therapeutically with Alan, using Eye Movement Desensitisation Reprocessing (EMDR) and had discharged him three years before the commencement of the study. Prior knowledge allowed me privileged access and might have influenced their decisions to volunteer as participants. There was a risk of the participants assuming any intervention I made would be beneficial. The halo effect (Koch and Forgas, 2012; Forgas, 2011) is discussed in chapters 3.3 and 7.4.

The study participants

The veterans were drawn from the same geographical area. They self-selected and all were male and white-British. Further details of the participants (Figure 4.1) revealed that they had all been diagnosed with PTSD more than ten years ago and had left the armed forces between 7 and 36 years ago. The mixed methods study involved the idiographic in-depth study of the three veterans' perspectives on whether dramatherapy might contribute towards recovery from PTS and integration into civilian life. Their views were influenced by their backgrounds and stages in their life journeys. The small number of participants precluded generalisability of results.

Time limitations

The 8 sessions for focussed dramatherapy only provided an exploration of the potential for dramatherapy in the treatment of trauma. Someone newly diagnosed or affected by psychological trauma, might take that number of sessions, or more, in assessment and trust building before therapeutic interventions can be commenced.

1.10 My personal journey to the start of this study

I commenced my nursing career in the mid 1970s. Some ‘long-stay’ patients had been in the ‘asylum’ (often their description of the psychiatric hospital) since the end of World War I (WWI). Some had found sanctuary working on the hospital farm and had graduated to ‘ward captains’, standing in for staff, shepherding other patients, greeting the lost. Some, it emerged, had been corporals in the war, so would have had that close duty of caring for their men. Looking at some old medical notes there were still diagnoses such as ‘Low Moral Fibre’ LMF’ and ‘Neurasthenia’ (Reid, 2014). The ultimate cost of this suffering in WWI was to be shot for cowardice. I remember within the body of case notes reference being made to ‘shell shock’ but I do not recall that ever being entered in the diagnosis section. I also recall a psychiatrist explaining to me that during WWI and WWII, suicide was considered a crime, and unsuccessful attempts would lead to arrest. (Suicide remained illegal in England and Wales until 1961.) She said the figures suggesting that people coped better with trauma and loss in those wars were skewed, because wherever possible she and her colleagues would give another diagnosis. I can still picture some patients who shared their stories of combat and loss, which haunted them, many years on, and before treatments were as defined as now. It was this and my passion to bear effective witness and support for their stories that led me to specialize in this work. I had in mind the personal stories of these often-forgotten people that languished in long-stay psychiatric hospitals.

I embarked on my training as a dramatherapist in 1989. My motivation was to learn other ways to enable people in psychological distress to gain or regain a sense that life is worth living. I discovered how valuable dramatherapy is for people who do not have the words to describe traumatic experiences. I was supported in this specialisation by many people, particularly individuals I had worked with therapeutically. A colleague, consultant psychiatrist Dr. Peter Urwin, had served in the Royal Navy. When he learnt of my work and my interest in the plight of some veterans, he facilitated a placement for me in 1990 at the Royal Naval Hospital in Portsmouth, UK, to work alongside military therapists on the first British course for military personnel diagnosed as suffering from PTSD. The openness of the attendees, the staff team, led by Captain Morgan O’Connell RN, and the introduction of some dramatherapy methods began building the foundations of my work with some serving personnel and veterans. Research has always underpinned my practice –

research that I feel naturally occurs as I seek to assess what occurs within the therapy, training or supervision session as well as the formal studies I have undertaken, such as my M.Phil. in the assessment and treatment of PTSD.

Colleagues and veterans have encouraged me to write further of the work I do alongside veterans suffering from psychological difficulties, but the ‘busyness’ or business of life and the weight of referrals meant there was never enough time. I was aware that further research was needed to investigate whether the dramatherapy methods used could contribute to the treatment of veterans experiencing PTS, hence this study.

My work with veterans continues to this point – although, perhaps, retirement looms. The veterans I have worked with now have more voice than those I encountered back in the 1970s. However, I feel as they have trustingly and generously, sometimes painfully, shared their journeys with me, I should examine, from their perspective, whether dramatherapy has something to offer in the treatment of psychological trauma and their transition to civilian life. To continue with the journey metaphor, if at times I act as the guide, I have a responsibility to study the maps and record my findings. I reflect on my personal journey through this study in 7.7.

1.11 Summary

In this chapter I set out my plan for the research journey and provided a framework to act as a guide as I sought with the assistance of the research participants, to find answers to the research questions. The contextual background provided a foundation, showing the history of developments that led to the recognition of a cluster of signs and symptoms, defined as PTSD. I have highlighted that a review of literature revealed that no robust studies existed to examine veterans’ perspectives of whether dramatherapy was helpful. This gap in the literature led to the formulation of my research questions. The defined purpose of the study incorporated my clinical background, military influences and curiosity in my aim to discover the answers to these questions, putting the perceptions of the participants at the centre of the study (Lawn et al., 2007; Swift and Dieppe, 2005); whilst being informed by the analysis of the qualitative and quantitative data generated in the fieldwork. The structure of the fieldwork, using the concept of ‘journeying’, provided a protocol of specific dramatherapy interventions that would be subject to the analysis.

The phenomenological mixed methods case study (Flyvbjerg, 2006; Thomas, 2010, 2011; Yin, 2012) using IPA ensured that the veterans' voices were heard in the study (J.A. Smith et al. 2009; Hefferon and Gil-Rodriguez, 2011, 2015). The qualitative analysis and the universal self-report quantitative measures provided a basis for triangulation of the results.

The next chapter reviews critical literature that provided signposts for that journey, some of which were followed, others noted for the contribution they have made to the field of dramatherapy, psychological trauma, psychiatry, psychology and anthropology.

Chapter 2 Mapping the Territory

2.1 Introduction

Chapter 1 set out the aims of the study and the research questions, which were formulated after a gap was identified during my review of the literature (see below). This chapter reviews historical and recent debates about military mental health, which were relevant to this study. Further contextual information including suicide rates; managing risk, stigma and help-seeking; the psychological health of veterans compared with that of the general population, and risk factors for psychological ill health among combat veterans are in Appendix 2. This discussion provides an overview of PTSD treatments, and the use of arts therapies, and dramatherapy in particular, the participant's perspective to treat combat trauma.

2.2 The literature review

The bodies of knowledge consulted include dramatherapy and the wider arts therapies publications; Ministry of Defence research papers; and US research into military mental health, psychiatry and developmental psychology. My main source for the military research was a review of literature relating to the British Armed Forces and psychological trauma post-2003 up to 2014. Many of the military research papers referred to were from The King's Centre for Military Health Research Institute of Psychiatry (KCMHR), King's College London, which is one of the leading research centres for military psychological health in the UK. The longitudinal studies it conducts are important in informing government policy and recommending and supporting interventions to reduce the risk of psychological injuries among armed service personnel (Iversen et al., 2009; 2011; Rona et al., 2012). The centre was created from the Gulf War Illnesses Research Unit, an independent research body set up and funded by the Ministry of Defence (MoD) to assess the health of the British Armed Forces and veterans who had served in the Gulf War. The original cohort was those who had served in the Gulf or elsewhere in March 2003, excluding those in the Special Forces or involved in high security operations. A total of 17,698 individuals were identified, of which 10,272 agreed to take part (Hotopf et al.,

2006; Fear et al., 2010). Pinder et al. (2012) state that the total sample represented 4.6% of the serving UK Armed Forces. The King's Cohort study oversampled reservists by a ratio of 2:1. Other studies have shown that reservists had a greater risk of developing psychological difficulties relating to their service experience (M. Jones et al., 2008; Iversen et al., 2009; Harvey et al., 2011; Hunt et al., 2014). In view of the oversampling of reservists in the King's cohort study, care should be taken when drawing conclusions about the overall psychological difficulties encountered in the Armed Forces.

A comparable study, the Millennium Cohort, was begun in the United States (T.C. Smith et al., 2008). Both the KCMHR and US cohorts cover the main period of counterinsurgency operations in Iraq and latterly Afghanistan. I therefore included key studies from the United States. There are cultural differences in American Forces compared to British. The diagnostic methods vary, with the Clinician Administered PTSD scale (CAPS) (Mueser et al., 2001) being routinely applied to all American service personnel reporting psychological difficulties. CAPS is regarded as the gold standard in PTSD assessment. It takes 30–60 minutes to administer by someone trained in its use and a little less time to score (Weathers et. al., 2001). This may be the reason for it not being routinely used in the UK. The prevalence of PTSD among US forces returning from Iraq and Afghanistan has been reported as between 9 and 20% of combat personnel (T.C. Smith et al., 2008). This compares to the 3–7% of UK military personnel reported to have PTSD (Wells et al., 2011). Sundin et al. (2014) suggest a reason for this difference may be that the US Millennium cohort study is based on those involved in direct combat whereas the KCMHR cohort involved all those serving in Iraq and/or Afghanistan.

An additional factor for including US military studies is that arts therapies and dramatherapy are used within the military and veteran psychological treatment centres. The arts therapies literature cited below includes pioneering work in the field of combat trauma. This lays out the journey towards the use of the arts therapies in the treatment of veterans suffering from trauma. Cultural issues are referenced where relevant to this study. Much of the arts therapies literature is presented in case study form. The studies included, are those, which satisfy critical analysis in terms of an evidence base (Gilroy, 2006).

Exclusion criteria

Studies that related to under-18-year-olds are not included unless the approach has been adapted to use with those aged 18 years and over. Non-English language works are not included unless a critiqued translation was available and the findings are relevant to UK-based military personnel or veterans. Popular literature such as newspaper and magazine articles were not used.

Literature search methods

A systematic search was used for each section listed below and in appendix 2. Key terms were searched, including: veterans; military mental health; depression; anxiety; psychoses; alcohol dependence; PTSD; psychological trauma; childhood; resilience; service personnel transition; combined terms – veterans' comorbidity; reservists; homelessness, suicide, employment; adjustment; risk factors.

Arts therapies were searched using key terms relating generally to arts therapies combined with the word *trauma*, i.e. dramatherapy; drama; music therapy; art therapy; dance and movement therapy; embodiment; evidence-based. Adding the terms military or veteran filtered the search further.

The initial review of the literature to establish the gap in literature took place before the fieldwork in 2013. However the methodology, in particular IPA, calls for the suspension of preconceptions in order to be open to new phenomena arising. This led to further exploration of the literature up to 2016.

2.3 Military mental health

Historical context

Over time there have been alterations in the way the military view mental health (E. Jones et al., 2002; Greenberg et al., 2011a). It is not clear whether these adjustments are a result of changing attitudes within the military environment, UK society or both. From 1914 to 2014 Britain had been at war or involved in armed military conflict almost continuously (Appendix 2).

The treatment for shellshock or ‘neurasthenia’ in 1914 often took the form of anaesthesia using chloroform or ether, or electric shock treatment (McKenzie, 2012; Reid, 2014). By 1918 talking therapy, predominantly psychoanalysis influenced by Freud’s teaching, was employed for the officer ranks (McKenzie, 2012). Those more severely affected were admitted to asylums, where no specific treatment to address their symptoms was available. Historical records suggest that officers received more psychological help and support than soldiers. Webb (2006) examined both patient and War Office records of Craiglockhart hospital in Scotland, which was open from October 1916 to March 1919 and has been credited with the development of pioneering treatment for some officers affected by shellshock. Webb reveals that the talking therapy methods used at Craiglockhart were not well received by the military establishment and some senior military doctors from the War Office, who did not accept the diagnosis of shellshock and regarded it as malingering. Webb’s examination of the historic records at Craiglockhart shows that William Halse Rivers, the military doctor often seen as in charge of the psychologically wounded at Craiglockhart Hospital, was in post at Craiglockhart from October 1916 until October 1917. Young’s (2004) view of Rivers, however, contrasts with the popular (fictional) view of Rivers as a pioneer in the field of shellshock (e.g. Pat Barker’s *The Eye in the Door* and Sebastian Faulks’ *Birdsong*). According to Young: ‘... [Rivers] promoted the questionable idea that officers had a more refined ‘epicritic’ sensibility, while the other ranks could only muster a crude ‘protopathic’ response (Young, 1997, p.82).

While Young questioned Rivers’ role in the treatment of shellshock this does not indicate a complete disagreement with Rivers’ approach. There is some agreement on the role of memory in the development of trauma. Rivers in his evidence to the War Office Committee Enquiry into Shellshock (1922, p.56) expresses the idea that his patients experience symptoms and then seeks to find an explanation. Young asserts that PTSD is an invention of DSM-III. He does not dispute that people diagnosed with PTSD are experiencing distress. His position is that memory can be formed to explain the symptoms being experienced rather than be in itself the cause of the symptoms. He compares the situation during WWI and WWII when rival theories concerning trauma were hotly debated and the ‘doctor’s job was to make men fit to return to service, not provide a way out’ (Young, 2004, p.138). He contrasts this to post-war 1980 (and post- DSM-III) when attention focused on individual war veterans and the acceptance of the ‘iconic traumatic memory’ as central to the clinical diagnosis of PTSD. Leese (2001) reviews four essays on shellshock (by Babington, Binneveld, Holden and Young) and concludes that Young

brings out what the other authors miss, and that our knowledge of the social history of medical practice is incomplete. Reid (2014), in her examination of the history of shellshock, its treatment and the development of the diagnosis of PTSD, states: ‘...it is still difficult to commemorate and remember the mental wounds of war in a culture which tends to glory or glamorise military heroes’ (Reid, 2014, p.91). In all of these studies it is accepted that individuals are experiencing psychological difficulties. The debate is whether it should be labelled as PTSD.

Comorbidity and complexity – validity of treatment recommendations

When evaluating research studies from the largest UK cohort study into military mental health (Hotopf et al., 2006; Iversen et al., 2009; Fear et al., 2010), an issue to consider was whether the veteran was classed as ‘help-seeking’ (Spinazzola, Blaustein and van der Kolk, 2005). In their meta-analysis Spinazzola and colleagues make the case for future research to include those with severe comorbid psychopathology. They reason that this will enable better testing of the validity of treatments offered. A further meta-analysis (Gerger, Munder and Barth, 2013) refers to treatment outcomes for veterans with both complex and non-complex clinical problems. Their results confirm moderate superiority for specific National Institute for Health and Care Excellence (NICE) recommended psychological interventions for those with non-complex PTSD. However they state that the superiority of clinical guideline-recommended treatment was small in complex PTSD treatment. Whilst key studies exclude those with severe comorbidity such as concurrent addiction, depression, anxiety, and psychosis, we should ask whether the data can be relied on to meet the needs of all veterans with psychological difficulties arising from or compounded by traumatic experiences (Ford, 1999).

Poor mental health prior to and during service as a risk factor

A longitudinal study (Iversen, Dyson and Smith, 2005) followed up a cohort of randomly selected Service personnel consisting of 8195 soldiers who served in the armed forces in 1991, not all of them in the front line. The researchers analysed data and concluded that those who were well and gained employment on leaving the Services remained well. Those with poor mental health during service were more likely to leave and had a greater chance of becoming unemployed after leaving. The inference drawn from this in the report summary was that mental health problems appear to remain static for veterans after leaving the services. The report acknowledges that, although they only identified a small number

of veterans affected by mental health issues, during and after service, this group should be regarded as vulnerable. Iversen et al (2005) comment that those with pre-service mental health problems do less well. As discussed above, on enlistment psychological screening only takes place for potential officers, so the risk factor referred to by Iversen et al. (2005) may require further investigation.

The findings of Berntsen et al. (2012), a Danish study examining pre-, peri- and post-war levels of PTSD in military personnel serving in Afghanistan (included here because there are few studies of this type), indicate that those who had experienced childhood trauma briefly improved in mental health whilst in battle. This improvement was not maintained and that cohort showed greater deterioration 3 months post-return. There were no studies that reported the percentage of recruits who experienced childhood adversity, but did not develop psychological problems. For those who do develop long-term mental health difficulties it is not possible to say whether this would have occurred if they had not been exposed to combat incidents.

2.4 PTSD diagnosis and treatment recommendations

In the UK the NICE recommends CBT or Eye Movement Desensitisation Reprocessing (EMDR) for simple trauma (NICE, 2005). CBT uses some interventions common to dramatherapy such as role-play and rehearsal (Edelman and Chambless, 1995; Morgenstern and Longabaugh, 2000; Blacker, Watson and Beech, 2008). Dramatherapy also has some interventions similar to EMDR such as safe place identification, visualisation, rehearsal and movement (J. Fisher, 2000; Kinowski, 2003; Martin, 2008). For complex trauma amongst veterans NICE suggests a referral to specialist treatment (NICE, 2005). They do not say what this treatment may entail. However they state in the guideline that there is no evidence that the arts therapies are effective. The evidence base is focused on Randomised Control Trials (RCTs); the NICE review calls for further RCTs and adequately powered trials. The guideline review in 2015 resulted in a decision to update the guidelines but this was not yet available, previous reviews have not resulted in any changes to the guidelines. The Royal College of Psychiatrists' Education Committee (2013) recommends CBT or EMDR for acute PTSD. In addition to this they state that some body-focused therapies may help in managing the stress. For complex PTSD, in addition to this they recommend grounding techniques, psychodynamic therapy or other

psychotherapy. They advise that ‘care needs to be taken as treatment can make the condition worse’ (Royal College of Psychiatrists, 2013, p.10). Advances in neurobiology, discussed in Chapter 1, demonstrate the involvement of the whole body in response to trauma (P.A. Levine, 1997; van der Kolk, 2006). This is recognised by some practitioners (Rothschild, 2003; Talwar, 2007; Hefferon et al., 2010; Baum, 2013) and action therapies are recommended. Dramatherapy is one of these action therapies, as the therapist attends to body movement and quality of action. Combat veterans suffering from trauma may have marked tremors and exaggerated startle responses (Kessler et al., 2005; American Psychiatric Association, 1994). These physical reactions associated with combatants across the centuries are seen in traumatised combatants from recent conflicts (Walters and Hening, 1992; Orr et al., 2004; S.K. Levine, 2009). Another research report recommends a multi-modal therapy approach, including dramatherapy, to address the neurobiological manifestations that may occur with PTSD (Hogberg et al. 2011).

2.5 Arts therapies, combat and trauma

This section introduces research into and approaches of arts therapies that are relevant to the field of adults suffering from psychological trauma, with a particular focus on the use of dramatherapy with combat veterans.

Arts therapies and trauma

There is little empirical research into the use of the arts therapies in the area of psychological trauma, assert Foa et al. (2009), who call for more empirical research and a manualised PTSD protocol for arts therapists. The (non-arts) treatments recommended by Foa and colleagues have been evidenced by randomised control trials (RCT). In the same publication Johnson, Lahad and Gray (2009) provide an overview of creative therapies for adults. When considering the theoretical context they assert the importance of imaginal exposure in trauma treatment. Parallels are drawn between creative arts therapy interventions and cognitive approaches (figure 2.1). They state that empirical research confirms the effectiveness of the elements listed in cognitive approaches for PTSD interventions, these share a commonality with elements in the creative arts therapies. In addition they assert that creative arts therapies make a unique contribution through the ability to address the nonlexical systems where traumatic memories are stored (Johnson, 1987; van der Kolk, 1994). They posit the engagement of the senses and creation of

representational artefacts might lead to more vivid imaginal exposure. Furthermore they observe that the creative arts can be of additional help to people who are unable to verbalise their traumatic experiences. This may act as a bridge to regaining or progressing on their developmental path. This supports Jennings (1992, 2012) Embodiment, Projection, Role (EPR) developmental theory, discussed further below.

One recommendation they make is that creative arts therapy treatments specifically for PTSD are developed and tested. This would ascertain if they have a more marked therapeutic effect than other creative arts therapies approaches.

Therapeutic element	Creative Arts Therapies	CBT	Aim
Imaginal exposure	Dramatic role play, movement, artwork, poetry, music, creative imagination, guided imagery	Guided imagery used in desensitisation models of CBT	Overcoming avoidant behaviours
Cognitive restructuring	Role playing, playing scenes, switching roles	Role play and covert role play.	Elicits new behaviours and expands role choice. Repetition reduces anxiety
Cognitive interventions	Journaling, writing and storytelling. Identification of distorted cognitions and reprocessing / reframing of trauma narrative. Often preceded by non verbal interventions	Journaling, writing and storytelling. Identification of distorted cognitions and reprocessing / reframing of trauma narrative.	Impact clients' narratives of their traumatic experiences
Stress/anxiety management	Relaxation techniques. Attention to breathing, muscular tonality and heart rate	Relaxation techniques. Attention to breathing, muscular tonality and heart rate	Improved regulation of physiological responses
Resilience enhancement	Creativity, humour, spontaneity, flexibility, activity	Importance of creativity, humour, spontaneity, flexibility, activity	Improvement in self-esteem, hope and prosocial behaviour
Testimonial methods	Performance and exhibition of creative works by trauma victims	Testimony, education	Destigmatisation and reintegration into society

Figure 2.1 Therapeutic elements of Creative Arts Therapies and CBT adapted from Johnson, Lahad and Gray (2009, pp. 480-481)

Whilst considering this I turned to the work of Gilroy (2006). Whilst reviewing the literature relating to arts therapy and trauma, I have focused on the levels of evidence identified by Gilroy and these are referred to in diagrammatic form (see Figure 2.2). She placed case studies and phenomenological research at level 1b.

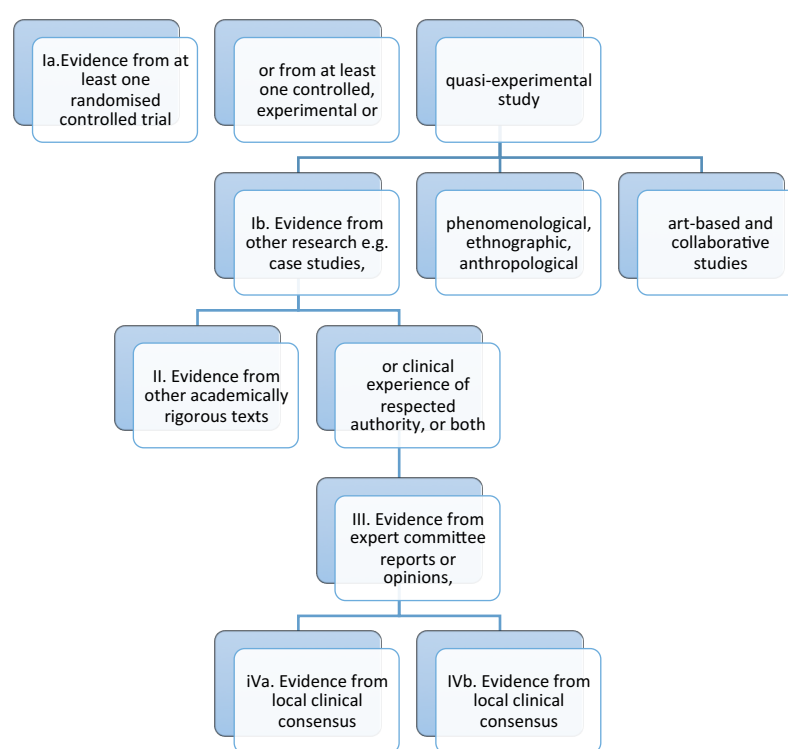


Figure 2.2 Art psychotherapy levels of evidence (adapted from Brooker et al., 2007, p.18)

Arts therapies have from their inception been connected with the treatment of trauma. P. Jones (2005) provides definitions of music therapy, art therapy, dramatherapy and dance movement therapy. He draws attention to the re-emergence of arts within health care following the two 20th-century world wars, giving the example of musicians being invited into US hospitals to work with veterans suffering from mental and physical trauma. Demand for arts based therapy led to a need for training and one of the first degree-level

music therapy trainings was established at the Michigan State University in 1944 (Bunt and Stige, 2014). Hill (1945) served with the Royal Artillery Company, combining his activities in the Scouting and Sniping Section with work as a war artist in WWI. He was hospitalised for the treatment of tuberculosis in 1938, and as he recovered he began to pass the time with art and encouraged other patients to do similar. He was invited to extend this to the treatment of injured soldiers and then civilians. He first used the term Art Therapy in 1942 (Hogan, 2001). Hill believed that war damaged ‘minds, bodies and hopes’ (Hill, 1945, p.132) He asserted that the creative process of art could lead to healing and turn society away from war. In 1942 Marian Chace began her pioneering work using dance and movement within a 4000-bed psychiatric hospital in Washington DC (Levy, 1995). Amongst the patients she treated were servicemen (Sandel et al. 1993). Her background was as a dancer but she and the medical profession recognised that she was able to communicate through dance and movement with patients previously considered inaccessible (Levy, 1987). She became the first paid dance therapist and continued to work therapeutically with servicemen for the next thirty years. In 1966 she founded the first training course for dance therapy (Levy, 1995; Karkou, 2012).

Sutton (2002) provides an international perspective on how music therapy is used to treat psychological trauma. In common with earlier arts therapies research is mainly based on descriptive case studies (Sutton, 2002; Wigram et al. 2002).

These texts form practice-based evidence and come within the scope of Brooker’s Hierarchy of Evidence (Figure 2.2). Talwar (2007) recommends an art therapy treatment protocol. He explains that under stress people often lose the ability to speak and emphasises that non-verbal therapy may prove particularly suitable. Music therapy research also refers to the importance of the non-verbal form of communication for those individuals unable to verbalise their traumatic experiences (Sutton, 2002; Bunt and Stige, 2014). Music therapy research with soldiers suffering from PTSD examines six soldiers’ responses to the therapy (Bensimon, Amir and Wolf, 2008). In the speciality of trauma within the arts therapies there are some similarities in assessment, treatment and evaluation. An emphasis is placed on the therapist being trained and experienced in the therapy and in the speciality of psychological trauma. The NHS and referring bodies demand that commissioned services are able to demonstrate positive outcomes for the assessment and treatment of individuals and groups suffering from psychological trauma. This demand is amplified in the case of Combat Veterans (NICE, 2005; McGeorge, Hacker et al. 2006; Foa et al., 2009). Researchers and practitioners in the arts therapies are

responding to this challenge, which covers every area of arts therapy practice, and the body of information on the application of research to practice continues to grow. Karkou and Sanderson (2006) provided a map of the diverse research in the arts therapies completed and being undertaken in the UK. Landy (2006) referred to traumatic events occurring throughout the world from and emphasised the need for practitioners to engage in research. This need for engagement in research extends further than the field of psychological trauma. P. Jones (2009, 2012) makes a plea for research, which does not favour one type of research above all others and is pluralist. He emphasised the voice and concerns of the client should be central. He reminds the reader that the most healthy research is one that supports a diversity of roles and researchers. This inclusivity makes the research more relevant as a dynamic process. There are calls for arts practitioners to engage in thorough evaluation of their innovative ways of working to demonstrate whether and how it is beneficial to recipients (Grainger 2001; Karkou, 2012; Smyth and Nobel, 2012).

Context of dramatherapy and trauma

Slade (1955) is often credited with being the first to use the term *dramatherapy* based on his 25 years of observations of children using dramatic play. In fact Austin (1917) used the term earlier, in a hyphenated form -- *drama-therapy*. Austin was based in New York. In the Foreword to his book he refers to clear 'scientific inquiry'. He asserts that '... the chances are [the researcher] will find that a curative drama is not only a present possibility, but that it presupposes, only a mere extension of known laws ...' (p.x). P. Jones, (2013) contrasts the fully formed ideas of Austin with the more recent views that dramatherapy had evolved over time. Jones suggests that the psychotherapy profession needs to revise its historical view of the development of dramatherapy and take cognizance of the primacy given by Austin to drama as containing the therapy. Jones finds no response to Austin's request that other 'creatives' correspond with him on this matter, nor has he unearthed any further writings from Austin on the subject. Austin refers to *neurasthenia*, widely used to include those exhibiting the signs and symptoms of psychological trauma or shellshock, in his studies. The controversy over the term *shell shock* caused it to be expunged from many UK military records in 1918 and there was a refusal by those within the senior military ranks to admit that such a condition existed, it was re-termed as Not Yet Diagnosed, Nervous (NYDN) (Jones and Wessely, 2005b.; Loughran, 2012). Austin's book was published during WWI, at a time when 'nerve' hospitals such as Craiglockhart in

Edinburgh were admitting soldiers suffering from severe psychological symptoms (Rivers, 1918; Webb, 2006; Linden et al. 2013).

In the UK the use of drama to resolve psychological difficulties is not novel. Casson (1997) has chronicled drama and other creative methods being employed in therapy since the mid-19th century. This includes the use of theatre at Ticehurst Asylum in England, with the intent of ‘curing diseased minds’ (P. Jones, 1996).

A pioneer of dramatherapy in the UK, Jennings (1992) identified EPR as a developmental model initially devised for use with children. Extensive work with this model demonstrated it was not confined to use with the 0-7 age group and could be applied to adults who had suffered trauma in childhood or later and that trauma had impacted on their psychological development (Jennings, 2012). The theme of projection and role is also apparent in the work of Landy (1993, 1996, 2010). He theorises that people are role players and role takers and this ability increases as part of human development. Landy’s role theory assessment does not require a person to act out a role but their ability to think themselves into a role (Landy and Butler, 2012). Someone whose life has been impacted by trauma might have difficulty in engaging with this process or the revelation of imbalanced roles. The assessment provides the dramatherapist and client with a foundation for planning interventions aimed at restoring the balance. Pendzik (2006) recognises the need to ensure balance and the importance of maintaining safety whilst working with vulnerable individuals. Building on the work of Lahad (2000) Pendzik asserts that dramatic reality is a core concept of dramatherapy. In her view it applies to all dramatherapists regardless of their therapeutic orientation. She identifies 4 main tasks of the dramatherapist in connection with it.

- 1. Facilitate the transition between ordinary and dramatic realities*
- 2. Sustain, support and enrich the materialization of dramatic reality*
- 3. Make therapeutic interventions in dramatic reality*
- 4. Help individuals to integrate dramatic reality and every day life.*

(Pendzik, 2006, p.276)

She emphasises the dramatherapist’s responsibility for ensuring the vulnerable client, in particular, safe exit from dramatic reality to ordinary reality. This echoes the assertions of

other dramatherapists. They remind practitioners of the importance of differentiating between the space of every day living and the ‘as if’ space, where the imagination constructs and deconstructs dramatic reality (Gersie, 1991; Jennings, 1992; Johnson, 2000; P. Jones, 2007; Lahad and Doron, 2010).

Dramatherapy and combat trauma

Two leading post-doctoral researchers, dramatherapists Johnson and Lahad, have published widely in the field of combat and trauma. Lahad focuses on trauma and resilience in young people and families affected by combat (Lahad, 1992, 1995; Lahad and Cohen, 1988). Although Lahad is best known for his work with young people, his methods of assessment and interventions are applicable to adults. Lahad developed a therapeutic intervention, Six Piece Storymaking (6PSM) (Lahad and Dent-Brown, 2011; Lahad, et al. 2013) an arts-based method of assessment of coping skills and resilience that has been used in his work with young people suffering from trauma. 6PSM has also been used in practice-based research with individuals and groups suffering from trauma, including veterans (Winn, 1994, 1998, 2011). Landy has published widely on dramatherapy and his role taxonomy (Landy, 1991, 1993) includes soldier and warrior. Landy (2006) in his keynote speech to the National Association for Drama Therapy (NADT) reflecting on the terrorist attack of 9/11 pleaded:

Dramatherapists need to be on the front lines when there is war, terrorism, disaster, genocide, racism and homophobia, and when there are cultural models of mental health treatment that speaks to the strengths and wellness of individuals, rather than pathology ... (p.140).

Johnson and myself are two dramatherapists who have worked extensively with combat veterans. I have researched the use of a model of dramatherapy in the assessment and treatment of trauma (Winn, 1998, 2011). Johnson has extensively published his clinical-based research (Johnson, 1987, 2009a., 2009b., 2010a., 2010b.; Bremner et al., 1993; Johnson et al., 1996; Johnson and Feldman, 1995). I base my integrated approach with veterans in a structured way using key concepts and an educational element, which incorporates CBT. The approaches may be different but

there are similarities highlighted in Figure 2.2. Johnson's work has evolved into Developmental Transformations (DvT) (Johnson, 2000). According to Johnson (2009b) DvT is the transformation of embodied encounters in the playspace. The therapist emerges themselves spontaneously in the client/s play. The first sessions with DvT are underpinned with discussions around safety. The DvT sessions are client-led and therefore will only progress from the 'surface play' to deep play' when the client guides the DvT therapist to do so. All the time the client is held in a structured play space and the therapist may step out of role as necessary to maintain this element of safety (Johnson and Emunah, 2009.) I build safety in the preparation phases of the 'Seven Key Concepts of Treatment' (Winn, 1994):

1. Assurance of confidentiality and trust building
2. The educational element anxiety management, what PTSD is.

(Winn p.45)

Johnson and myself use the concept of the liminal space. The term liminal comes from the Latin, *Limen*, meaning at the threshold, the term used to denote the base of a doorway, which needs to be crossed to enter a building. (Turner, 1967; Jennings, 1987; Turner and Schechner, 1988; Harris, 2009). It was first used by Van Gennep (1966) in his anthropological studies of Rites de Passage. He identified three stages in ritual, firstly as the person separates from their previous life, followed by the liminal phase as the person transitions into their new life, finally they move to a new social status. Turner used the three stages as a foundation for his model; he frequently describes liminality as 'betwixt and between' (Turner, 1975). He sees it as a temporal state, something people transition through, to a new state of being. This is framed by his studies of ritual. I conceptualise the liminal space as one of resting and restoration, leading to transformation (Winn, 1998). Johnson's 'play-space' resonates with the liminal space. He identifies times when energy shifts, and for reasons beyond scientific understanding, transformations occur. He has used DvT with Vietnam War veterans (Johnson, 2010b). Boundaries are set. There is a defined play-space into which participants step. This is a transitional area; when the performance (therapy session) ends, the space once more becomes the here and now. Johnson (1992) promotes the use of humour as a paradoxical response to traumatic memories.

The provocative playfulness engendered provides an opportunity to reframe the client's response. He uses 'bracketing' where he may suggest, for example, that the action is being played out on the television, serving as a reminder that it is removed from reality, which provides some protection to the participant or therapist from being overwhelmed. Johnson elects to work this way; he rejects constructivist role theory and narrative therapy in favour of a more spiritual worldview, according to Landy (2008).

Johnson (2010b) provides a descriptive case study of a veterans' performance project in the US. The veterans found the performance helpful to them, reflecting on their experiences, with their enactment being witnessed by friends and family in the audience. The performance also gave credence to their therapeutic work. Despite this, the veterans did not feel that the audience understood their experience. Johnson describes the audience as passive, bound by the conventions of theatre.

Johnson and myself at the time of my fieldwork were the only dramatherapists based in the West, working with veterans, researching and publishing details of this work. We have different theoretical, professional and cultural backgrounds. Some shared principles, however, are demonstrated in Figure 2.3. Landy is included as his methods of work, in particular, aesthetic distancing influenced my approach to working with trauma.

Therapist	Assessment	Safety	Structure	Interventions	Aims
Johnson, D.R.	Detailed Trauma Inquiry (DTI) includes risk assessment	Detailed explanation of DvT. Boundaries: clients whose behaviour is out of control; have intense dislike of drama; or body movement DvT not recommended (Johnson and Emunah (2009)	Mutuality between client / therapist. No pre-planned structure. Clearly defined play-space provides physical container (Johnson, D.R. 2000, Johnson, D.R. et al. 2004)	Embarks on a journey, dealing with the impact of traumatic experiences. Desensitisation (Sajnani and Johnson, D.R., 2014)	Aids clients in desensitising from fear-based schemas that are disrupting lives (Johnson, D.R. 2014)
Landy, R.J.	DTI, Role Profiles Card Sort, Role Checklist, Tell-A-Story (TAS) (Landy et al., 2011)	Modulating levels of affect to minimize the possibility of re-traumatization (Landy, 2007)	Safety created by distancing through role, story structure and performance	Director role, aesthetic distancing, projective techniques, role repertoire, taxonomy of roles, derolling (Landy, 1993, 1996)	Transformation of potential trauma in real life, into safely contained enactment. To extract a sense of meaning from a tragedy (Landy, 2010 p10-11)
Winn, L.C.	DTI Communiwell 6PSM	Detailed explanation of treatment and boundaries. Session will not proceed if participant's behaviour adversely affected by drugs or alcohol on arrival.	Sessions underpinned by trauma focused dramatherapy structure (Redfern, 2014). Session mutually agreed between therapist / client. Safe space identified, (physical or 'mind's eye' space).	Educational - includes how individual may react to trauma and ways to manage anxiety. Dramatherapy based in theme of journeying forward (Winn 1994, 1998). Props used. Exploration through distancing and metaphor.	Aids clients to move towards recovery; building on previous strengths and identifying new skills (Winn, 1994, 1998, 2011)

Figure 2.3 Johnson, Landy and Winn's modes of working with psychological trauma

Johnson, Landy and I ensure a preparation phase that must include a detailed trauma inquiry. The formulation from this will include consideration of whether dramatherapy is the most suitable treatment for that individual's distress. We emphasise that the therapist should be trained to work with individuals who have suffered trauma. Each dramatherapist's aim is towards the client(s) being able to integrate and then move on from the constraints of the traumatic experience. A factor not always taken into account is the level of experience and supervision the dramatherapist has in working with these methods

and a particular client group and or culture. It is important that dramatherapists understand the needs of special populations so that they are respectful and can instil confidence in those they work with (Johnson, Lahad and Gray, 2009). Without appropriate training and the development of skills in the treatment of psychological trauma, there is a risk that the dramatherapist could further traumatise the client/s. Clinical supervision is a vital part of working with trauma (Winn, 1994; Tselikas-Portmann, 1999). In addition to professional and ethical responsibilities, supervision plays an important role in reducing the risk of vicarious PTSD (Lahad, 2000; P. Jones and Dokter, 2008).

Recovery

The term *recovery* is increasingly used in mental health. In some physical illnesses, such as motor neurone disease, or insulin dependent diabetes, there is no expectation of complete recovery; instead the focus is on managing the long-term illness. In mental health the health systems, practitioner, and person receiving treatment may hold variant pictures of what recovery looks like. The use of outcome scales contributes to information on how the person has fared in treatment, but it may not accord with that person's own view. He or she might be expecting to feel fantastic, sometimes better than the general population, or alternatively may experience even a slight reduction in symptoms to be life changing. This reflects the individuality of each of us. There is a need to beware of the application of a *one-size fits all* approach to the treatment of psychological difficulties according to Evans (2012). There is an argument to consider the needs of the individual and that may begin with more compassionate services according to recipients of mental health care (Spandler and Stickley, 2011). I would assert that there are some people, who do recover from psychological trauma although my conception is not that they forget it, rather that they come to accommodate it (Winn, 1994, 1998; Rothschild, 2003; Armstrong, Best, and Domenici, 2009; Schiraldi, 2009). This suggests that the improvement may come about from integrating the experience through, for example, acceptance, gaining justice, making personal sense of what has happened or through the support of others being able to move forward with living. There are different categories of recovery (Herman 1992). This is often termed Post Traumatic Growth (PTG) (Dekel, Mandl and Solomon, 2011; Joseph, Murphy and Regel, 2012; O'Rourke, Tallman and Altmaier, 2008). Lloyd et al. (2008) identify multiple domains: clinical recovery, personal recovery, social recovery and functional recovery. Clinical recovery from a physical injury may denote actual

recovery or adaptation to a changed body. Personal recovery might be the individual's perception that they have recovered even though others might not share the opinion. Social recovery might involve a move back into society and seeing oneself as having a place there. Functional recovery might be when a person is witnessed as taking part in everyday life and adapting to changed circumstances. The crucial thing is that all these aspects of recovery go beyond what can be measured through clinical assessments and scales. The sense of recovery is very personal to the individual and to a large extent a reflection on their personal schemas.

Adjustment to civilian life

The difficulty in adjustment to civilian life is highlighted as a concern in research findings (Ozer et al., 2003; Browne et al., 2007; Iversen et al., 2008). A veteran may show recovery or reduction of troublesome symptoms and yet remain isolated from reintegration into society. They may have difficulty gaining or maintaining employment (Johnson et al., 2004; Harvey et al., 2011; Hatch et al., 2013;).

2.6 Conclusion

Although I identified a dearth of research into dramatherapy with veterans this is not true in the wider field of psychological studies concerning serving and former military personnel. There is an increasing amount of research into the psychological health of military personnel and war veterans, in the UK largely centred on the KCMHR cohort studies (Iversen, Dyson and Smith, 2005). Much of this research is based on examination of postal questionnaires and telephone interviews (Hotopf et al., 2006; Iversen et al., 2011). There has been a lower response rate among early service leavers, lower ranks and the younger age group (Iversen et al., 2010; Goodwin and Rona, 2013). Mental health surveys have excluded the homeless and those in long-term care (Spinazzola, Blaustein and van der Kolk, 2005). Until 2013 NHS statistics have not automatically recorded whether an individual has served in the military (Gill et al. 1996; Jenkins et al., 2009). Samele (2013) reviewed the evidence of key stakeholders. Identified gaps in knowledge included the need for more social psychological research to understand behaviour in a group context.

Research has shown that the majority of service leavers do well after leaving the military and whilst in military service suffer less mental ill health than the rest of the population

(Greenberg et al., 2011a; Hunt et al., 2014). The vulnerable veteran however continues to cause concern (Deahl, Klein, Alexander, 2011). The NHS, charities and voluntary organisations are all involved in supporting the veterans, their supporters and families. The suicide rate amongst young male serving personnel and veterans remains higher than the general population (Cooper et al., 2002; Windfuhr et al., 2008). There is still a stigma against seeking help for mental health problems (Iversen et al., 2011). Comorbidity may make the problem of seeking help greater. Although there are some specialist services that will address alcohol and drug misuse problems, many NHS and voluntary organisations require that the veteran addresses their dependence problems before engaging in trauma-focused treatment. Engaging the veteran in treatment may be the biggest challenge for the therapist, and the arts therapies may have something particular to offer here. Art, drama and music are popular amongst serving personnel. In Section 1.6 I explained the use of drama, play and other creative medium within the military. If someone is suffering from trauma, to introduce them to a new concept (such as some of the psychological therapies) may feel a step too far for them. Using a familiar medium, in a different way will not provoke so much anxiety (Winn, 1994, 1998). Foa and Gillihan (2013) draw attention to the need to disseminate research into practice. They comment on the efficacy of Prolonged Exposure (P.E.) and the reluctance for clinicians to adopt this method for the treatment of PTSD. Instead, their research demonstrates that many clinicians prefer familiar interventions, even if unproven. In my assertion that a familiar medium is important to the person being treated for psychological trauma, there came a need to examine whether veterans were of the opinion that dramatherapy would make a useful contribution. Much of the research in military mental health has concentrated on occurrence and diagnoses, which are vital in the planning of responsive services. In Chapter 3 I posit there is an additional factor to consider due to the dearth of research on the topic. What might contribute to the psychologically injured veteran's recovery and reintegration into the community, from their perspective?

There is a move towards recommendations for multi-modal therapy to address the neuro-biological response to trauma held in the body (P.A. Levine, 1997; van der Kolk, 2005; Hogberg et al., 2011). This review of literature demonstrated a growing body of knowledge concerning the arts therapies and trauma, for which the evidence mainly fell within levels Ib, II and III (Brooker et al., 2007; see Figure 2.2). A literature search of the arts therapies revealed no research that examined the use of the dramatherapy in the

assessment and treatment of combat veterans in a way that sought to capture the veterans' perspectives of whether dramatherapy is useful or a hindrance to recovery.

Dramatherapists are now working with veterans but with the exception of US-based therapists (Johnson 1987; Johnson et al., 1996; Johnson and Lubin, 1997) who have published theory and research extensively, and myself as a UK-based dramatherapist Winn (1994, 1998) the search of literature found no published research-based studies in the use of dramatherapy with veterans within the English-speaking Western Hemisphere, which sought to discover how the process affects the participants and captured their views, in addition to using standardised and arts based measures.

In this thesis I have addressed an aspect of this gap in the knowledge through the research questions:

What is the participant's perspective on the use of dramatherapy in helping British combat veterans a) to recover from PTSD? and b) to adjust to civilian life?

This chapter has detailed those areas that form the foundation for further research. In Chapter 3 I elaborate on my research question and my research design.

Chapter 3 The guidebook: Research Methods and Study Design

3.1 Introduction

Chapter 1 gave the background and purpose of this study. Chapter 2 examined studies for the treatment of veterans suffering from trauma and the strengths and weaknesses of studies involving the arts in the assessment and treatment of trauma. It also highlighted a gap in research on veterans' perceptions of whether the use of dramatherapy helps in their recovery from psychological trauma. This chapter affirms the research questions. It defines the methodology used to address these questions. I argue the rationale for the choices made. Following this the conceptual framework for the research is detailed. This includes the context of the study and the participant selection; the methods for data collection and analysis are described. The relevant ethics and participant consent are then defined. The limitations of this study are stated. A summary concludes the chapter.

3.2 The research questions

As stated in Chapter 1, the purpose of this study was to investigate whether, from the perspective of the participants, dramatherapy contributes usefully in the treatment of psychological trauma experienced by them and this formed the research question:

- What is the participant's perspective on the use of dramatherapy in helping British combat veterans a) to recover from PTSD? and b) to adjust to civilian life?

It was clear from the literature review in Chapter 2 that there was a scarcity of studies regarding dramatherapy as a vehicle to assist adjustment to life outside of the armed forces. Yet this difficulty in the transition to life as a civilian has been highlighted as a cause of concern. Indeed, as noted in my commentary on the history of military psychological trauma (Section 2.3 and appendix 2) this concern stretches back through the centuries.

The published research literature showed no direct reference to the views of the veterans receiving dramatherapy. Dramatherapists have captured participants' perspectives in research with other client populations (Casson, 2001; Dokter, 2008; Bar-Yitzhak, 2010). This raised the importance of discerning whether veterans found dramatherapy to be useful in their journey towards recovery.

3.3 The study design

Conceptual and theoretical issues

My review of the primary literature relating to veterans and PTSD and then narrowing to veterans suffering from psychological trauma, showed that clients' views were not explicit within the studies. My own earlier research described clients' actions, verbal responses and stories (Winn, 1994, 1998). It did not examine clients' views of the dramatherapy process. James et al. (1996) provide a detailed paper on dramatherapy with a Vietnam veterans' group. It provides an excellent description of what took place in the session, but it does not include the participants' views of the dramatherapy. Bensimon, Amir, Wolf. (2008) study captured veterans' perspectives during and reflecting on drumming sessions, however that is based on music therapy. In clinical practice, during the closure phase of a session, it is common for group members or individuals to feed back their view of what has taken place. This information may sit within clinical process notes. Likewise, the dramatherapist will make notes on their own responses to what has taken place; however, this is not explicit within quantitative research studies. It might be reflected in outcome questionnaires but does not translate to the numerical data within reports. When seeking to make a decision on something that may have an impact on my life, in common with many others, I look for further information. This may be in the form of reading research papers and examining statistics. It would also involve seeking the opinion of others who have experience in that field. Practice Based Evidence (PBE) adds to my knowledge of the subject. My decision would be based on the arts psychotherapy levels of evidence (Gilroy, 2006) and referred to in Figure 2.2 (Brooker, 2007). If the reports fall within the hierarchy it might lead me to adopt that particular strategy (Wertz, 2005; Hinds, 2011). I juxtaposed seeking of PBE with my position as an interpretative phenomenological researcher. I follow the principles of hermeneutic research developed initially from Heidegger in his response to the philosophical position of Husserl. Whilst Heidegger agreed with Husserl's position 'to the things themselves' he rejected Husserl's naturalistic, descriptive approach and emphasis on the subject being in their natural state, pre-reflection (van Manen, 1990). Heidegger favoured understanding and being in the world. He argued that phenomenology should be studied through interpretation that lay beyond the initial consciousness and cerebral observations. (Heidegger, 1962; Moustakas, 1994; Dowling, 2007). In order to make more practical sense of this and how it applies to clinical research I turned to the assertion that

that body and mind cannot be separated out, we are of the world and in the world (Merleau-Ponty, 2012). Both therapist and client react to the world we find ourselves in and the world and those in it react to us. The idea of bracketing, setting aside all preconceptions is not possible, a case has been put forward for the term ‘bridling’ (Dahlberg et al. 2008). This term is used to emphasise the discipline of not only taking consideration of pre-understanding, but not jumping to conclusions, instead waiting for the phenomenon to reveal itself. It is about a close dwelling with the phenomenon. Rather than using energy in the holding back associated with bracketing, Dahlberg et al. explain bridling as directing the energy in an open way, allowing the emergence of the phenomena. I see this as similar to what takes place in a therapy session, where more information can emerge if the client is given space and respect to unfurl their story. This is further explained in the relationship between therapist and client (Finlay, 2011). There is the potential for demand characteristics to occur (Orne, 1962). Participants in research might act in a particular way, because they think it is expected of them, or to try to please the researcher. This risk is amplified when the researcher is also the practitioner. There is a potential for the halo effect, where the participants defer to the supposed ‘expertise’ of the practitioner, convinced that any interventions would be of benefit (Forgas, 2011; Koch and Forgas, 2012). There is a risk that to take statements at face value might be misleading (Harper, 2012). Adherence to the methodology reduces the potential for researcher/practitioner bias. It is the conceptual framework and the underpinning methodology, which provides the opportunity to uncover hidden aspects. It delves beneath the obvious in a planned, structured way, to answer the research questions; in addition to providing dramatherapy to the research participants. It does so through using dramatherapy methods and I argue this provides an insight for clinicians who work with veterans. With a small sample size replicability and generalisability are not functions of this study. The detail of the design and fieldwork methods might provide other practitioners with PBE to underpin their clinical work or as a basis for further research.

The choice of design and rationale

This section explains my reasoning behind the choice of a phenomenological mixed methods case study. The design provided the framework for in-depth exploration of the participants’ perspectives on the whether dramatherapy might contribute towards recovery from trauma and adjustment to civilian life. The phenomenological mixed methods case research provided triangulation of the PBE. The general outcome measures assists non-arts

therapists to consider the contribution that dramatherapy might make in the recovery process, while the arts-based measures will assist other arts therapists to make comparisons between their practice and this research. The IPA analysis provided information concerning the participant's perspective on the use of dramatherapy in helping British combat veterans a) to recover from PTSD and b) to adjust to civilian life.

The rationale for mixed methods

The core of the research was a phenomenological case study (Moustakas, 1994). A mixed methods design was used (Creswell, 2014). Aldridge (2005) advocates the use of mixed methods in case-study research, arguing that the multiple levels of analysis and flexible design allow for the therapy to adapt as the patient changes. The naturalistic setting of the research mirrored the therapy setting and so informed practice. Yin (2013) explains that a case study is an empirical method used to understand a contemporary phenomenon in depth and within its real-life context. This form of inquiry is able to cope with the technically distinctive situation containing many more variables of interest than data points. The analysis of multiple sources of evidence with the need for the data to converge in a triangulating fashion is highlighted by Yin (2013) as distinctive from historical, survey-based or experimental study. Odell-Miller, Hughes, Westacott (2006) refer to a mixed methods case study and they make a sound case for the use of general as well as arts-based measures. Odell-Miller emphasises the importance of using client-centred techniques, and questions whether it is better to examine the outcomes of the process or analyse sessions in depth. Additionally, Odell-Miller, Hughes, Westacott (2006) ask whether it is better to look at change achieved in areas general to the patient. They emphasise the importance of these changes to the well being of patients suffering from mental health problems. Odell-Miller, Hughes, Westacott (2006). conclude that it is important to measure generalities in addition to arts-based parameters. They advocate the use of client-centred techniques such as self-report questionnaires. Mixed methods allow for the use of universal measures, which will be familiar to the wider field of clinicians and therapists. The criticism that mixed methods fail to deliver large enough samples to be of statistical significance and therefore generalisability is countered by the greater accessibility it gives to researchers, practitioners, services users and funders to gain a multi-dimensional view on the usefulness of treatment when interpreting results (Mertens, 2010; Creswell, 2011a; Creswell, 2014). The multiple methods synthesis has the potential to raise questions and give new insights rather than confirm the results. This is termed

crystallization (Ellingson, 2009). Ellingson draws a distinction between crystallisation and mixed methods triangulation. She concedes that there are similarities and it may provide a useful adjunct if the researcher accepts that there is no such thing as the whole truth, in the quest for answers. Crystallisation emphasises a creative response to the many facets of a phenomenon. My research design did not follow the framework for crystallisation but, through the multiple dramatherapy methods, acknowledged the contribution a pluralistic approach can make, if the dichotomy between science and art is bridged by the acknowledgement that, through plumbing the depths of the data, one may glimpse other forms of truth (Smith, 2011). The combination of qualitative measures and quantitative participant rated questionnaires captured the many facets of the participants' perspectives of dramatherapy in helping to recover from PTSD and to adjust to civilian life.

The choice of a phenomenological mixed methods case study and rationale

The case study research was underpinned by robust research methodology, this differentiates it from the more widely available case reports. The research methods detailed in the next section fulfilled the essential aspects identified by Smeijsters and Aasgaard (2005). These are:

- specific and particular, not a sample from a population and not an aggregation across cases,
- complex in its functioning, with working parts,
- a bounded system, differentiated from the environment,
- grounded in real life, related to contemporary events. (pp. 440–441).

Although they are discussing the aspects required for a qualitative case study this is also appropriate for a mixed methods case study.

The mixed methods approach allowed for a variety of data collection and analytical methods. The data transcripts were member-checked and the IPA independent peer-checked (Appendix 11). This approach ensured that the data analysis reflected a variety of perspectives. (Triangulation of the data is discussed in Section 3.6).

The phenomenological aspect of the case study goes beyond the direct observation and analysis of the data. It delves into the phenomenon of what is being claimed. Something

hidden is uncovered. The word *phenomenon* comes from the Greek ‘to flare up’; as something flares it sheds light on areas that may have been hidden. Preconceptions need to be set aside, in order for the researcher to be open to the unexpected. These new insights are then taken back to the original source where they illuminate that process (Moustakas, 1994). This in turn gives new weight to the text. When referring to entering the hermeneutic circle, Heidegger (1962, p.195) asserts:

...we must come in to it ... leaping into it primordially and wholly. In the circle there is positive possibility of the most primordial kind of knowing ...

The dramatherapist recognises the symbolism of the circle in performance. It is an ancient arena, where new and old material is tried out, risks are taken, and rehearsal takes place with the possibility of new understandings and strengths emerging. I assert that this commonality of understanding between dramatherapy and phenomenological research assists in the sense making that is required when seeking a participant’s perspective in dramatherapy. Other dramatherapists have utilised phenomenological research as they have sought to illuminate aspects of practice (Biggerstaff and Thompson, 2008; Dokter, 2008; Carr and Andersen-Warren, 2012).

Thomas (2011) amplifies the resonance between drama and case studies in his explanation of case study research (p.188):

Think of the substance of the case study as a play [...] complete with:

- a script, plot and leitmotif (provided by life and the world)
- a stage and scenery (the wider context)
- dramatis personae (a list of characters, institutions or agents)
- a director (you)
- an audience (your readers).

Thomas invokes Shakespeare to reinforce this view:

All the world’s a stage,
And all the men and women merely players;
They have their exits and their entrances.

(*As You Like It*, 2.7: 139–141)

It may be argued that this quotation has become over-used however it is a demonstration how the words of Shakespeare have been adopted to illustrate many of life's situations. Thomas suggests that this quotation could be the guiding principle for the case researcher. He argues that this text gives context to scenarios. Situations are affected by communications between individuals, circumstances and the setting. Thomas's guiding principle for case-study research, taking his example from Shakespeare's play, resonates strongly with my dramatherapy perspective. This is explored in the analysis of my fieldwork in Chapter 5. Thomas' elaboration of Shakespeare's metaphor of the stage accentuates his belief in the case study to explore life in its many contexts. Similarly the importance of Shakespeare as prompter in differing life situations is recognised (Cox and Theilgaard, 1994, pp.207). Comparing interactions in the universal theatre [world], they speak of hidden characters; sole authors; people not knowing their lines or not being able to act in the way they want. Dramatherapy draws on such metaphors, playing with them, remoulding and stretching to paradoxically draw closer to the underlying challenges. The case study enables the underlying 'secret theatre self' (Cox and Theilgaard, 1994, pp. 259) to be explored.

My research questions sought the participants' perspectives on the use of dramatherapy in helping British combat veterans to recover from PTSD and to adjust to civilian life. The case study ensured their views remained central.

The case study is criticised by some for its lack of robust data and generalizability (Campbell and Stanley, 1966) Campbell originally asserted that case studies were only suitable for pilot studies. He later revised this opinion, acknowledging the importance of the case study in theory building (Campbell, 1975). One argument against a case study is that it is context-dependent and cannot be replicated. Flyvbjerg (2006) critiques five common misunderstandings about case-study research (Figure 3.1). He asserts that rule-based knowledge is important to the novice but, as a researchers develop expertise, they learn through intimate knowledge of several thousand cases in their area of expertise. Flyvbjerg concludes that his revision of the misunderstanding of the usefulness of the case study in social science research should not lead to an either/or approach. He draws attention to the Kuhnian assertion that thoroughly executed case studies provide exemplars, essential for developing knowledge (Kuhn, 1987). Large random samples providing a breadth of information across an entire population and the single thick descriptive case study are both imperative for social science research. Case study research can make a contribution to theory if the study design is robust. Rowley (2002), a

management studies researcher, sums up the issue of generalisations in a case study by reframing the issue. Instead of requiring large numbers of participants in a study, she asks whether the research can add to the theory. However, she stresses the need for a robust study design. It is essential that the case study is multi-faceted and uses multiple sources of evidence. She emphasises the importance of a chain of evidence.

No.	Misunderstanding	Corrections
1	General, theoretical knowledge more important than concrete, practical knowledge	Universal truths cannot be applied in the study of human affairs. Concrete, context based knowledge is more valuable
2	Lack of generalisability means the case study cannot contribute to scientific knowledge	Formal generalisation is over-rated as a source of scientific development. The use of examples and transferability are underestimated
3	The case study is most useful for forming a hypothesis as a prelude to hypothesis testing and theory building using other research methods	The case study is useful for generating and testing hypotheses. It is not limited to these activities
4	The case study contains a bias towards the researcher's prior views	The case study contains no greater bias towards than any other method of inquiry
5	Case studies often are difficult to summarise or generalise from	Summarising case studies is difficult. Often it is not desirable to summarise and generalise case studies. Good studies should be read as narratives in their entirety

Figure 3.1 Five misunderstandings about case-study research (adapted from Flyvbjerg, 2006, pp.219-245)

Thomas (2011) challenges the emphasis on inductive theory for case study research. His preference is to think of the case study as being a process of abduction, analysing complex detail, which by the nature of variables cannot be replicated. He turns to the contribution case study research makes through phronesis, summarising Aristotle's concept as a model based on personal experience ... it helps us to make sense of particular situations (p.214). Thomas is a qualitative researcher, and I find his viewpoint of the case study being a wrapper for different methods (p.44) illuminating. It reminds me that various components can be selected to investigate the research questions and be held within that wrapper. My research design ensured an evidence base. It comprised interview notes, questionnaires, transcripts, reflexive activity and supervision notes that backed up the study. This matrix of

different types of evidence is what moves the research from a historical or narrative study to a case study (Yin, 2012).

I applied a template (Thomas, 2011). It led me on the journey through the design. Using this typology, my research question pathway is shown in Figure 3.2. The typology was used to check that my research questions were suitable for a case study. The case study concentrates on the ‘why and how’ of research (Yin, 2013). It is not necessary for a case study to meet all the criteria within Thomas’s typology; however, if a section does not contain suitable criteria, then it would suggest that another method may be more suitable. Thomas defines three kinds of case study in his model: the key case, an outlier case and a local knowledge case. The key case is something that is considered classic or exemplary. I did not opt for this definition, as my research was not based on a widely established practice, and an outlier case is necessarily something outside of the norm. At this stage dramatherapy with veterans could not be considered exemplary as there was not sufficient prior research with which to make comparison, since dramatherapy practice with that client group is not widespread.

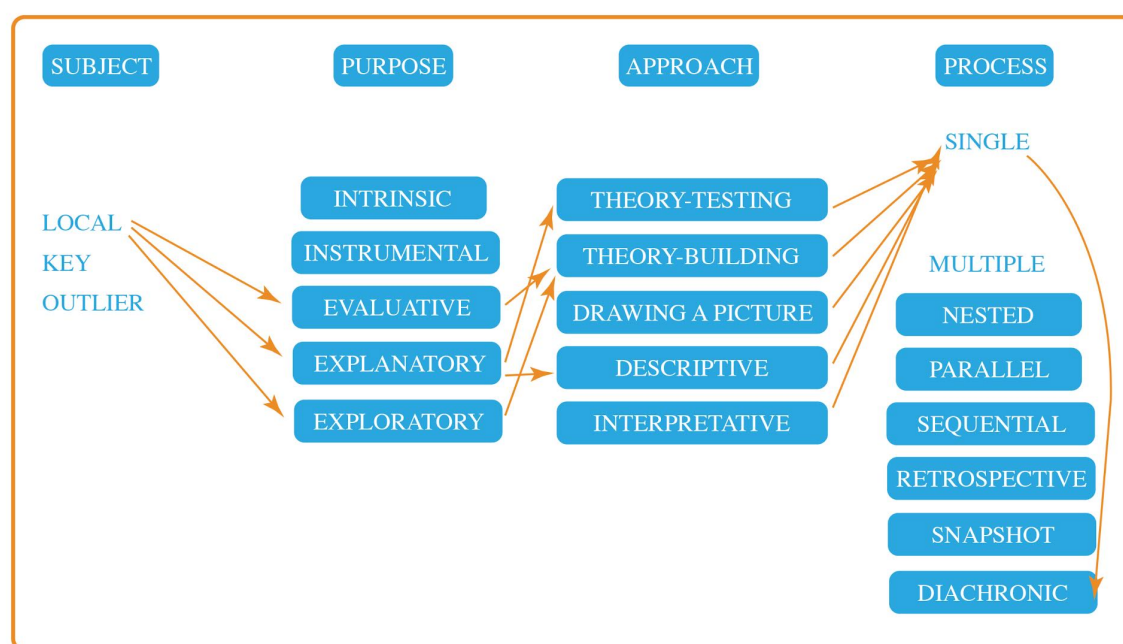


Figure 3.2 Research question pathway (adapted from Thomas, 2011, p.518)

I therefore designated my case study as a local knowledge case. The criterion for this was that it is an example within my personal clinical practice that I wanted to investigate further. The purpose of the research was to evaluate the assessment and treatment process. The research sought explanation through analysis of the data. It explored the responses of

veterans to the dramatherapy process. The approach included some theory-testing, but this was limited as there is little theory specific to dramatherapy and the treatment of veterans suffering from trauma. Theory-building was prominent and was based on the analysis of the fieldwork (Thomas, 2011). There was a descriptive approach to what happened in the therapy sessions. The interpretative criteria arose through the analysis of the transcripts and the themes that emerged. Finally, the process was that of a single case study. It was more than a 'snapshot' as the sessions took place over several months, with follow-up reflection sessions and discussion of the IPA themes. The process was diachronic, as it evaluated change over a period of time (Thomas, 2010). Most importantly for the purpose of answering the research questions, it ensured that the participants' voices were given prominence.

The approach of being the dramatherapist / researcher in the sessions allowed me to capture Alan, Jack and Chris's actions and reactions providing a richer data source. It remains though, my interpretation of their actions, reactions and their reactions. The case study acted as a wrapper for the various sources of data collected. This wrapper holds the narrative as the connections are made between the data (Thomas, 2010; Becker, 1998). The mixed methods research from this study were case-oriented. The quantitative element corroborated or provided another perspective to the data. The qualitative, mixed methods and quantitative "QUAL-MM-QUAN continuum" (Teddlie and Tashakkori, 2009) applied to this data situated my study towards the QUAL end of the scale.

The prominence of the qualitative findings that emerged from the fieldwork dictated that they came first in the discussion; this did not negate the importance of the quantitative results, particularly in the triangulation of the results. They are discussed prior to the mixing of the data. The inferences from both sets of data were synthesised to derive meta-inferences (Teddlie and Tashakkori, 2009).

3.4 The context

The dramatherapy research took place within a community setting. This did not give the control over variability that a laboratory setting or strictly clinical environment may have. However it was typical of the settings where outreach work and support is offered to veterans. The informal setting encourages attendance and allows greater flexibility in choosing venues that do not have negative associations or provoke traumatic memories in those seeking assistance. Chapter 2 concluded that there is a dearth of research in the use

of dramatherapy in the treatment of veterans suffering from the effects of psychological trauma. The literature review revealed that few studies reported veterans' perspectives of assessment and treatment and none examined the participant's perspective on the use of dramatherapy in helping veterans to recover from PTSD and to adjust to civilian life.

This research design, contributed another dimension to the study of serving personnel and veterans that is taking place in the UK (Harvey et al., 2011; Macmanus et al., 2014).

3.5 Participant selection

Posters detailing the research project were displayed in a public place where veterans meet for informal peer support or for help with welfare benefits. These invited veterans who had been affected by traumatic experiences to take part in dramatherapy research (Appendix 3). Interested veterans were invited to an individual session to learn more about the research. As one of the difficulties for people suffering from trauma can be concentration, and some people have reading difficulties, a CD with details about the research was also produced. A full explanation of the research was provided and questions answered. Ethical considerations were explained. It was emphasised that participants would be able to withdraw their consent at any time, with no explanation, and this would not affect their access to treatment. Further written information was supplied in the information pack (Appendix 6). Would-be participants were encouraged to share this and discuss it with their supporters before making a decision.

The following selection criteria were devised:

- They had served in the British Armed Forces.
- They were over the age of 18 years.
- They were considered to have the mental capacity to make the decision to participate in the research.
- They were able to give informed consent.
- They had been psychologically affected by a service-related traumatic incident.

The participants were not permitted to take part in the research if any of the exclusion criteria applied:

- They were currently having dramatherapy treatment or another form of psychotherapy.

- They were considered by the researcher/practitioner or other clinician to be actively suicidal or pose a high risk to others.
- They were unable to give informed consent.

Three participants volunteered. They were all eligible to take part and they attended every session. Their anonymised details including previous therapy undertaken are given (Figure 4.1).

3.6 Data collection

The rationale for the choice of measures

The use of qualitative and quantitative outcome measures assists in a triangulation of the evidence. Guion, Diehl and McDonald (2011, p.511) make a distinction between five types of triangulation:

1. data triangulation;
2. investigator triangulation;
3. theory triangulation;
4. methodological triangulation;
5. environmental triangulation.

In my research, triangulation was achieved through data and methodology; the collection and comparison of data is from different sources, as recommended (Olsen, 2004; Campbell, 1975).

The rationale for quantitative measures

There are specific universal measures for the assessment and evaluation of treatment. I selected those in common use within mental health services in the UK. All of these measures have been tested for validity and the literature cited later in this section provides detail of the evaluations. In clinical practice, it is not unusual for there to be a requirement for all clinicians to use those measures. I routinely use them in my own practice. In Improving Access to Psychological Therapies NHS services (IAPT) in the UK there is a minimum data set of clinical measures that must be collected during each session (Clark et al. 2009; IAPT, 2011). Some studies have indicated that those accessing therapy have found regular tangible monitoring and discussion of the trajectory, helpful rather than adversely affecting the therapeutic relationship. (Crawford et al. 2011; Unsworth, Cowie.

and Green, 2012). The universal measures also provide a common language for practitioners from a wide range of clinical disciplines. The self-report universal measures have been chosen for validity and for being easy to score in sessions. This can be helpful to both the practitioner and the client as an indicator of change. These factors were taken into account when I selected the quantitative measures (see bullet list below). Specimen copies of the measures are in Appendix 4.

- PTSD Check List – Military (PCL-M: Weathers et al. 1991). PCL-M is a self-measure that veterans complete. It measures trauma-related symptoms specific to military experience. The scale has 17 items measured on a Likert scale of 1–5. It is used both as an indicator of PTSD and of change. It is based on the criteria for PTSD in DSM-IV-TR (Yarvis et al., 2012). It has now been superseded by the PCL-5 (Bovin et al., 2015) following the publication of DSM-5 (American Psychiatric Association, 2013). DSM-5 had not been published at the time of my fieldwork. PCL-5 is not specific to those who have served in the military.

The PCL-M is considered a useful measure to determine whether a person is making progress in treatment. Evaluation of the tool suggests that a 5–10 point change is not due to chance and that a 10–20 point change is clinically significant. A score of 44 is positive for PTSD for the general population and above 50 indicates PTSD in the military population (Mueser et al., 2001; Monson et al., 2008; Yarvis et al., 2012).

- Clinical Outcomes Routine Evaluation-34, known as CORE-34 and CORE-OM (Barkham, et al., 2001; Leach and Lucock, 2007) was completed at the commencement of the initial assessment and the commencement of the final session. This provided a measure of risk, in addition to an indication of levels of functioning, problems and well-being. A comprehensive guide is available, which includes how to score CORE-34 manually (Core System Group, 1988).
- Clinical Outcomes Routine Evaluation-10 (Leach and Lucock, 2007), referred to as CORE-10. As well as a method of collecting the research data, it serves as a measure of distress if someone is in need of further help from clinical services. Core-10 tracks response to treatment. It is necessary to consider the results separately from CORE-34. The clinical cut off point is above 11 for general psychological symptoms and a score above 13 indicates depression (Barkham, et al. 2013). CORE-10 was completed at the commencement of Sessions 2–7 (Barkham et

al. 2001). This provided a measure of the level of distress the participant had felt in the past week. With CORE the higher the score, the more the person is experiencing psychological distress. The clinical cut-off score for general psychological distress is 11.0. For depression, the cut-off score for the CORE-10 is 13 (Barkham et al. 2011; Barkham et al. 2013).

- Short Warwick-Edinburgh Mental Well-being Scale (SWEMBS: Stewart-Brown et al., 2009; Bartram et al. 2013). The SWEMWBS is now being widely used within UK community-based mental health services; unlike CORE the higher the score the greater the person's sense of well-being. The SWEMWBS was completed at the commencement of each session. This self-report scale demonstrates whether there is any change in the participants' sense of well-being. It consists of seven positively worded statements. It measures how the person feels, functions and evaluates their life from a personal perspective. It is a well-validated scale and has been used for population surveys. A national data comparator tool is available to compare with national population scores (Figure 3.3).

The score is in the top 20% of responses	Excellent
The score falls between the top 21% to 40% of responses	Good
The score falls between the 41% and 60% of responses	Average
The score falls between the bottom 61% and 80% of responses	Below average
The score falls in the bottom 20% of responses	Poor

Figure 3.3 SWEMWBS scoring guide (www.nef-consulting.co.uk)

The justification for collecting quantitative data in this phenomenological mixed methods case study was:

- To reflect the data collection that is required by many clinical services within the UK and evaluate how closely linked the data compares with the participants' views of progress.
- To provide an objective assessment measure of improvement/deterioration of individuals receiving dramatherapy.

The rationale for the choice of arts based / dramatherapy methods

The theme of the dramatherapy sessions was based on journeying towards recovery. The qualitative measures that were used help to set the scene for that journey. Assessment tools used were as follows:

- *6 Piece Story Making* (6PSM) is an assessment tool that, with BASIC Ph (Lahad, et al. 2013) provides information on coping skills and resilience of the story-maker /storyteller. The therapist observes and listens to the content, method and tone of the story. Using specified criteria within the 6PSM provides information to help define the focus of dramatherapy activities. This was used during the second session and repeated in the final group session.
- *Communiwell* (Casson, 2005), used as a clinical assessment tool. The clear acrylic construction of the model allows a three-dimensional overview of where a person sees themselves in relation to other factors in their life. Using a selection of objects, it provides information on current coping strategies using distancing and metaphor as a representation of the individual's story (Casson 2014). The application of IPA to this method of assessment provided a further measure for the purpose of this research.
- *Turner's Model of Crisis* (TMOC) (Turner, 1967, 1975; Winn, 1998), a paper-based method in the individual sessions and a movement method in the group activity. IPA provided the analysis for this method.
- *The play text extract from Homer's Odyssey* (Armitage, 2010;) was selected to reflect the themes of journeying and homecoming (appendix 1). The use of a play text reading was influenced by the work of Jenkyns (1996, 1999). The use and reworking of myth is something that has happened through the centuries as people have sought to understand the human condition (J. Campbell, 2008). Myths serve as endless reference points, regardless of culture. Reality and imagination entwine as people draw from myth, in order to find resonance with and make sense of the present. The struggles of Odysseus to escape from mythical powers to reality only demonstrates the entwinement of both, which eventually drags him back to the mythological (Habermas and Levin, 1982). Doty (2000 pp. 101) asserts that 'myths create imaginal totems of the nature: culture system.' Doty also writes of how myth and ritual serve social integrative functions surmounting threats to social order and strengthening social bonds (pp.

105). Doty explains Odysseus as ‘the heroic figure, seen in all his everyday shabbiness’ (pp. 148). The Odyssey tale of a hero juxtaposed with the unrecognised aspect of his character, lost and far from home; gave the opportunity for the study participants to recognise commonalities with Odysseus.

- *Transcripts of dramatherapy sessions* were analysed using IPA. This provided information on what took place within the sessions.
- *Interviews*: an unstructured interview (J.A. Smith et al. 2009; Hefferon and Gil-Rodriguez, 2015) took place in a reflective period immediately following each dramatherapy session. This data was coded and processed using IPA. The interview transcripts and coding was used to identify emerging themes (Strauss and Corbin, 1998; Yin, 2013).
- *Record-keeping*: As researcher I collated session notes of the plan, and activities and responses within the group. I kept a record of clinical supervision sessions that took place during the fieldwork sessions.

3.7 *The rationale for the Interpretative Phenomenological Analysis (IPA)*

IPA is carried out using transcripts of sessions, interviews and other relevant material such as writings, photographs or artwork. These are examined firstly at a descriptive level and then moving to an interpretative mode, referring back to the original data. Themes will begin to emerge from the data. These are then clustered and superordinate themes will manifest; using the concept of a magnet, drawing the theme towards the strongest pull from the superordinate theme assists in the organisation of the data (J.A. Smith et al. 2009; J.A. Smith, 2015). The themes move beyond the descriptive to deeper meaning. Each participant’s qualitative detail is examined in this way and set aside. The method requires looking anew at each case. This gives the opportunity for new themes to emerge and may highlight divergence as well as convergence once the analyst moves towards looking across the themes of all participants. There may at that stage be many themes but not all will relate to the research question and so will be dropped. At all times as part of the double hermeneutic the emerging themes remain tied to the original data. (J.A. Smith and Eatough, 2007). This dwelling with the data provides a rich analysis of the data. With a sample size of less than n.3 it is recommended that quotes from the participants are used to illustrate each sub-theme (J.A. Smith et al. 2009). This provides a context for the

interpretation. It also means that the participants' voices remain clear. This is crucial for a study that seeks to understand their perspectives (J.A. Smith, 2011; Finlay, 2011).

Before selecting IPA I examined several other methods for examining data. Quail and Peavy (1994) opt for a purely phenomenological study of a client in art therapy. The single case study uses retrospective interviews with the research participant. Via thorough analysis of these interviews, they seek to capture the essence of what the experience means to the participant. Their approach is similar to the process used in IPA. Their methodology is informed by Intentional Analysis (Husserl, 1999; Ricoeur, 1967). This is concerned with the human experience of a situation that has been lived through, where its various meanings and processes are then reflected upon by the researcher and participant (Moustakas, 1994; Dowling, 2007). Quail and Peavy's study illuminates, through description and comment, the experiences of the participant. They argue that this research design allows the art therapy to speak for itself and meaning to emerge much as it does in the enactment of creative processes. This concurs with McNiff's (1998) plea for arts-based inquiries. Leavy (2009) suggests that in addition to some research being entirely arts based, there is a place for arts-based practice as one component of a multi-method research project. The entirely arts-based process would have provided an opportunity to ensure that I captured the participants' creative responses to their trauma, used alone it would not have provided a perspective of the effects of their sense-making concerning the dramatherapy process.

Narrative inquiry

Narrative Inquiry was also a possibility. Hiles (2002) highlights the inclusion of the points of view and perspectives of participants. There is an emphasis that goes beyond objective reality and transcends through the imagination, from individual to collective story. He emphasises that there remains more work to be done on authenticity in his description of heuristic indwelling. He draws on the work of Douglass and Moustakas (1985) to further describe the transpersonal and spiritual nature of the inquiry, which goes beyond numbers and consciousness. I returned to my research question: What is the participant's perspective on the use of dramatherapy in helping British combat veterans a) to recover from PTSD? and b) to adjust to civilian life?

Narrative inquiry would not have acquired the information I was seeking as a practitioner/ researcher, to enable me to examine the process and capture the voices of participants through a multi-faceted view of the data.

Cooperative inquiry

Cooperative inquiry was an option. Heron (1996) explains one or two people may initiate the call to research, those who responded and became part of the cooperative inquiry would be involved in all the subsequent phases. He identified four phases of cooperative inquiry:

Stage 1 –The first reflection phase. During this phase the inquirers would choose the focus or topic of the inquiry and the plan of action

Stage 2 – The first action phase. The inquirers explore the inquiry topic, through a range of research skills and record the data generated

Stage 3 – Full immersion in the stage 2. This may lead to new discoveries or a change to the inquiry format

Stage 4 – The second reflection phase; the inquirers share data from the action phase. This may lead to an amendment of the inquiry topic

Subsequent stages will continue in a cyclic fashion of reflection-action-reflection and may be repeated for up to eight cycles

(Adapted from Heron, 1996 pp.59-60)

It would have ensured the veterans were co-researchers in the process. However I had already completed the initial literature review to define the gap and from this devised the research questions. The study participants would have needed to be involved from the outset and provide an equal input into what the research questions should be and how they would be investigated (Heron, 1996, 2001a,b).

After consideration of other possible methods, I elected to use IPA for the analysis of the qualitative component of the findings from all the fieldwork sessions, mainly to provide a rich description for the study of what makes the individual unique. The ‘double hermeneutic’ of IPA refers to the interpretation or sense-making process. This is elaborated as ‘the participant trying to make sense of his personal and social world, and the researcher

trying to make sense of the participant trying to make sense of that world' (Tomkins and Eatough, 2010; J.A. Smith and Eatough, 2007).

This study involved analysis of individual responses from the one-to-one sessions followed by analysis of the group sessions using IPA. Case studies are normally carried out using an idiographic approach, a term that originates from the Greek word *idios*, meaning 'peculiarity' or 'uniqueness'. This approach is suitable for case studies, informal interviews and unstructured interviews (McLeod, 2007). The study of a group commonly uses a nomothetic approach. Nomothetic derives from the Greek *nomothetikos*, meaning 'lawmaker' (*nomos* means law and *-thetēs* one who establishes). In psychology today, the term is used to describe the study of universal statements or laws. Quantitative methods are more commonly used in nomothetic studies, so a nomothetic (group) study versus an idiographic study might be problematic for IPA. Tomkins and Eatough (2010) discuss this within their paper on IPA and focus groups. They describe a further dimension that is added to the double hermeneutic, in which the participants try to understand both their own experience and that of other participants within the research group. Morgan (1997) and Smith (2004) advise that the group should be given priority because the construction of a thematic hierarchy is based on what was said overall, in which case the individual's perspectives may be eclipsed by the group (Tomkins and Eatough, 2010). Thus, the sorting of the themes might be biased towards the general rather than the individual. Even when individual perspectives are used to illustrate themes at a later stage, those themes have already been selected from the more generalised group concerns. This runs counter to IPA's strong idiographic ethos.

I gave this matter considerable reflection. The literature suggests that the IPA stance is evolving and may encompass the individual perspective while bringing something new to the study of groups, if the potential pitfalls are kept in sight (Hesse-Biber, 2010; Thomas, 2010; Creswell, 2011b). The intention of this phenomenological mixed methods research was to shed light on the factors that individuals encounter within the dramatherapy process. Participants do not live in isolation; ecological and external influences determine how the individual responds. I often explain to veterans that even if they were standing shoulder to shoulder during a critical incident, they would experience it in different ways, as each of us is unique. In life, we all bring prior experiences and different coping strategies. In this study, to counter the risk of the group experience subsuming the individual, individual responses were analysed before group responses. Group influences

were then considered using IPA (Tomkins and Eatough, 2010; Githaiga, 2014; Wagstaff, Jeong and Nolan, 2014). The structure of the fieldwork design allowed for this.

. J.A. Smith et al. (2009) suggest there is a choice of writing up the IPA as a case within the theme, or using the theme within the case. Choosing the first option allowed me to identify superordinate themes and subordinate themes across participants. In a small case sample such as this, evidence was given from each participant to support a detailed account of how it applied to the theme.

3.8 Ethics and consent

The participants recruited to the study were already experiencing the effects of psychological trauma. It was imperative that the dramatherapy did not increase their distress or re-traumatise them. The design of the fieldwork took this into account. There was flexibility in order to attend to what may develop during the process. This is further commented upon within chapter 4 when the fieldwork structure is discussed.

This study was approved and registered by the Anglia Ruskin University Research Ethics Committee (Appendix 5). Permission was given by the Royal British Legion drop-in premises for the sessions to be held there. The final session was arranged at a farm setting used by the veteran community and familiar to the participants. This space provided an opportunity to complete the theme of journeying. Public liability insurance was confirmed to cover the sessions and I hold my own professional indemnity insurance. (Specimen copies of the participant information sheet and consent form is available in Appendix 6.) The purpose of the research, the right to withdraw without penalty or impact upon access to treatment, potential research benefits, potential risks arising from the research, and limits of confidentiality, were explained to potential participants. Contact details for myself as the researcher/practitioner were provided to potential participants for questions about the research, as well as contact details of the research supervisor and university complaints department, in the event of a complaint or concern that a participant may not wish to discuss with me. As a dramatherapist registered with the Health and Care Professions Council (HCPC) and a nurse registered with the Nursing and Midwifery Council (NMC) I am bound by both sets of regulations. These regulations and Codes of Practice should be followed at all times, not just when providing a particular type of treatment. A copy of my professional codes and professional memberships including complaints procedures, were

provided to each participant. Questions concerning the study were answered. Participants were assured that they could leave the study without giving a reason at any time, by signing a withdrawal slip, which could be returned to me in the stamped addressed envelope. Alternatively, withdrawal from the study could be made verbally or electronically. Where applicable, the keyworker could also do this on the participant's behalf.

Assumptions

I made few assumptions: I assumed that the participants would be honest and open in their responses. The assurance of confidentiality, anonymity and the explicit assurance of the ability to withdraw consent at any time during the study should have contributed to their willingness to be truthful. I made an assumption that the choice of the phenomenological mixed methods case study was the most suitable for answering the research questions. I reasoned that the use of qualitative and quantitative measures would provide a fuller explanation of what occurs and provide the opportunity for triangulation of the results (Greene and Caracelli, 2003).

3.9 Summary

The multiple methods synthesis might raise questions and give new insights. In choosing a phenomenological mixed methods case study, I took all the above aspects into consideration. For the purpose of this investigation, I wanted to capture the participant's perspective on the use of dramatherapy in contributing to recovery from psychological trauma and the contribution it might make towards adjustment to civilian life. It is important that the research findings are accessible to other professions within the psychological trauma field and that they are available to the veteran community, so that an informed choice of therapy can be made.

The participants' centrality to this study comes into focus in Chapter 4. Their relevant anonymised details are provided, together with a description of the dramatherapy sessions' methods and content.

Chapter 4 Tools for the journey: Dramatherapy Methods

4.1 Introduction

In this chapter the participants are introduced (4.2). The treatment structure and rationale are described (4.3) and key dramatherapy procedures are outlined (4.4). The settings for the fieldwork have already been described in Section 3.8.

4.2 The participants

Three adult male veterans were recruited (Figure 4.1). They had a formal clinical diagnosis of PTSD (DSM-IV-TR, 2000), although this had not been a criterion for selection. The diagnoses of PTSD were related to military service. In addition to this Chris and Jack had experienced physical and psychological abuse in childhood. The participants chose pseudonyms to protect their identities, as Alan, Jack and Chris.

	Alan	Jack	Chris
Age	64	35	52
Service	Royal Marines	British Army Royal Air Force	British Army
Age at enlistment	18	Army 15 RAF 20	18
Age at discharge	24	27	25
Length of Service	6 years	10 years	7 years
Discharged from Service	1975	2005	1986
Where served	Singapore, Northern Ireland (N.I.) *	N.I.,* Falklands, Cyprus, Germany	N.I*, Kenya
Diagnosis	PTSD	PTSD	PTSD
Relationship status	Married	Married	Partner
Previous Therapy	CBT, EMDR, Warrior programme	CBT, Art Therapy, Warrior Programme	CBT, Anxiety Management

(*Active combat zones)

Figure 4.1 Participant details

4.3 Treatment structure and clinical rationale

Structure of sessions

Individual sessions: Each participant was scheduled for 5 individual therapy sessions with the researcher/practitioner, which involved the following structure:

- We met on a weekly basis for between 2 and 3 hours.
- The dramatherapy session for individuals lasted between 60 and 90 minutes.
- A 10–15 minute break occurred at the end of the therapy session.
- A further 60–90 minutes was allowed for reflection and discussion about the use of dramatherapy.

Group sessions: The veteran population is close-knit and had identified who else was taking part in the research through their social networks. After their fifth session, Alan, Jack and Chris requested that they meet as a group, as they wanted to share the experience. I discussed this with my academic and clinical supervisors. The study was phenomenological and this was a reflection of the process that was occurring. It was agreed that the participants would meet as a group. From a clinician's perspective, this was an acknowledgment of the self-determination of the participants. It also reflected a common clinical pathway in the NHS where guidelines recommend patients step up or down to group or individual work, depending on their progress (NICE, 2011). This guideline was one followed in my clinical practice. The number of dramatherapy sessions and content remained as previously planned. The concept of a journey still underpinned the research. The change was now there were companions [other study participants] travelling on the route. The length of the group sessions increased to allow time for each participant to engage in the dramatherapy and reflection period. The structure of the group session was as follows:

- We met on a weekly basis for 3–3.5 hours.
- The dramatherapy session for the group was between 1.5 and 2 hours

- A 15-minute break was provided at the end of the first hour. There was a further 10-minute break at the end of the dramatherapy session.
- There was a further hour for reflection and discussion about the use of dramatherapy.

The overarching and explicit fieldwork theme was 'journeying towards recovery'

The structure helped to provide a sense of direction and safety, which paradoxically allowed for deeper exploration of matters that arose during the dramatherapy (Gersie, 1996).

Session content

Each session had a warm-up phase. In the individual sessions, this may be a reflection on the previous session or what has happened since. Depending on the needs of the participant this might have involved some grounding or movement exercises. These were captured in the transcription and if relevant to the research questions were included within the IPA narrative. Similarly the closure phase took place in each session to ensure the person transitioned safely from the dramatherapy session to life outside the room. P.Jones (2007) emphasises the importance of the warm-up in forming the creative space. This allows the individual or group to transition into another mode. Jones explains the closure phase as a clearly defined part of the dramatherapy session, where there is a disengagement from the dramatic space. This might involve de-roling exercises from characters, leave-taking of objects if used, so that the person can take leave of the dramatic space. These phases are an important part of the dramatherapy structure (Jones, 1996, Langley, 2006). The main activity took place between the warm-up and closure phases.

Key dramatherapy procedures employed are discussed in detail below and included my rationale for using them within this research.

One-to-one sessions:

- Session 1: assessment using the universal measures CORE-34, SWEMWBS, and PCL-M. Dramatherapy assessment using 6PSM. Comments on session by participant. Diagonal sculpt at commencement and end of each session.

- Session 2: assessment using CORE-10, SWEMWBS. Dramatherapy assessment using the Communiwell. Comments on session by participant. Diagonal sculpt at commencement and end of each session.
- Session 3: Universal measures using CORE-10, SWEMWBS. Dramatherapy – journeying theme using Turner’s Model of Crisis. Comments on session by participant. Diagonal sculpt at commencement and end of each session.
- Session 4: Universal measures: CORE-10, SWEMWBS. Dramatherapy using story making, with participant invited to bring in a story or poem that resonates with them. They may also bring in an artefact that illustrates their story. Short reading from *Homer’s Odyssey* (Armitage, 2010). Comments on session by participant. Diagonal sculpt at commencement and end of each session.
- Session 5: Universal measures: CORE-10, SWEMWBS. Dramatherapy – Text reading (Jenkyns, 1996, 1999) from *Homer’s Odyssey* (Armitage, 2010). Comments on session by participant. Diagonal sculpt at commencement and end of each session.

Group sessions:

- Session 6: Universal measures: CORE-10, SWEMWBS. Dramatherapy – Group text reading – *Homer’s Odyssey*. Comments on session by participant. Diagonal sculpt at commencement and end of each session.
- Session 7: Universal measures: CORE- 10, SWEMWBS. Dramatherapy – Story making with Turner’s Model. Comments on session by participant. Diagonal sculpt at commencement and end of each session.
- Session 8: Universal measures: CORE-34, SWEMWBS. PCL-M. Dramatherapy – *Odyssey* text sentences and 6PSM. Comments on session by participant. Diagonal sculpt at commencement and end of each session.
- 1-month and 3-month follow-up with participants using an unstructured interview.

4.4 Key dramatherapy procedures

I selected the dramatherapy interventions that reflect the process of making a journey. I based my decision on the assessment and treatment methods I normally use when working with those experiencing the effects of trauma. My research questions sought to illuminate the experience of veterans undertaking the dramatherapy and whether they considered it useful towards recovering from PTSD and in adjusting to civilian life. It was essential that I used authentic interventions.

Individual sessions

Session 1: 6PSM and BASIC Ph

For 6PSM AND BASIC Ph (Lahad, Schacham and Ayalon, 2013, Lahad and Dent-Brown, 2011) the participant is given a large piece of paper with an assortment of pens. They are asked to divide it into 6 areas however they wish as long as they don't tear or cut the paper. They are then invited to illustrate the themes (Figure 4.2).

1. Think of the main character – hero or heroine of any story, imaginary, legendary, film, show or simply make one up. Where does this character live?
2. What is the mission or task of that character?
3. Who or what can help that main character, if at all?
4. Who or what obstacle stands in the way of that character?
5. How will he/she cope with this obstacle?
6. Then what happened? Does it end or continue?

Figure 4.2 6PSM

They are then asked to tell the story from their illustration. I listen and apply their storytelling to the BASIC Ph assessment scale (Figure 4.3). As I listened to the story and later listened to the transcript I was able to grade the elements of the story as positive or negative elements.

Copies of Alan's, Jack's and Chris's illustrations are in Appendix 7.

Belief Systems	+
	-
Affect	+
	-
Social Support	+
	-
Imagination	+
	-
Cognition	+
	-
Physical Coping	+
	-

Figure 4.3 BASIC Ph assessment scale

Rationale The use of story to make sense of, or provide signposts through life is not novel. In his analysis of 100 Russian folk tales Propp (1968) identified seven dramatis personae involved in stories: the hero; the villain; the (sought for) princess and her father; the dispatcher; the donor; the helper and the false hero. Propp concluded the structure could be equally applied to modern stories. His analysis identified an underlying commonality, not dependent on the surface text of the tale, for example the underlying action might relate to loss or overcoming difficulties. The character was not restricted to one role (Propp, Wagner and Scott, 1969). The narratology perspective of Propp has been borne out in the development of the 6PSM. The 6PSM and BASIC Ph are used as a research tool in addition to being used in clinical practice, it has been refined to include the scoring of negative coping styles in addition to the original scoring of positive coping traits (Gersie, 1991; Lahad, 1992, 1995, 1997, 2000; Shacham and Lahad, 2004; Dent-Brown, 2011; Lahad et al., 2014).

The 6PSM provides a structure that encouraged a creative response from participants. It formed a foundation or preparation for the therapeutic journey. The main purpose was that it provided an assessment of coping styles. I noted that information as I planned the sessions to assist them to build on their strengths.

There are seven identified levels of assessment drawn from the 6PSM (Lahad, Schacham and Ayalon, 2013) For the purpose of this study I focussed on what the experience of 6PSM meant to the participants and whether it might contribute to recovery, for this reason my application of BASIC Ph was limited to the first 3 levels (Figure 4.4): the coping style,

the thematic level and the here and now questions. The 6PSM was further analysed using IPA.

Level 1	Level 2	Level 3	Level 4	Level 5	Level 6	Level 7
The coping style	The thematic level	The here and now questions	The conflict level	The developmental stage	The quest	Symbols

Figure 4.4 6PSM The seven levels of assessment

Session 2: The Communiwell

The communiwell was the second model to be developed following the communicube (www.communicube.co.uk; Casson, 2005). The clear acrylic construction of the model allows a three-dimensional overview of where a person sees themselves in relation to other factors in their life. I used the communiwell as opposed to the communicube as the circular shape with 3 concentric circles engraved on each of the 5 layers provides an unweighted neutral structure for the client to work with. The transparency allows the opportunity to view the construct from different perspectives. I have used sand-trays in the past (Winn, 1994) but many combat veterans who have served in desert locations have a negative response to the sand. A wide selection of objects were available to be selected for placement within the communiwell. Some objects were military related, such as toy tanks, shields and emergency vehicles, others were representative of life such as Russian dolls, figures and houses, finally there was the opportunity to select abstract objects such as buttons and stones. After selection and placement of the objects the participants were invited to describe their sculpt. To maintain distancing they are encouraged to talk in terms of the objects used rather than in the first person. When they were satisfied with their story, having had the opportunity to move things around or view from a different angle, the objects were then removed and de-rolled. The communiwell and communicube are widely used within dramatherapy. In December 2013 until August 2014 the communicube and communiwell were displayed as part of an exhibition 'MIND MAPS' at the Science Museum, London, acknowledging the impact of this tool in the field of psychological health. It is gaining popularity for wider applications. However it is not yet recognised as a research instrument. I assert that it provided information on the functioning level, support systems and creativity of the individual. I applied IPA to look beyond the immediate

presentation and ascertain whether the research participants viewed the communiwell as a helpful or hindering aspect of dramatherapy.

Rationale The communiwell provided a clinical method of assessment that assists me in discerning key concerns of the participant and the identification of coping resources. It also stimulates participants to share their stories whilst remaining distanced through the use of metaphors and symbols (Figure 4.5).



Figure 4.5 Examples of communiwells created by the participants

Session 3: Turner's Model of Crisis (TMOC)

I have adapted TMOC (Turner, 1967; Turner and Schechner, 1988) to use in dramatherapy both for assessment and treatment. It can be used in diagrammatic form (Figure 4.6) or a 3D model can be created from long cloths and props available in the room to create a pathway that can be walked through. Sometimes the use of the drawing will lead to a 'walk-through' at a later stage. In the individual session the diagram was used. Each participant identified their pathway through the model.

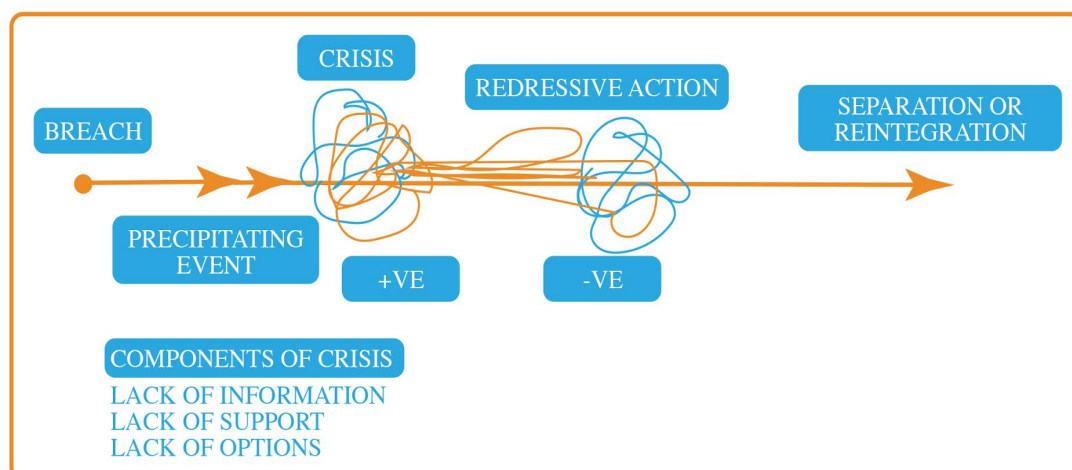


Figure 4.6 Diagrammatic form of Turner's Model of Crisis (adapted from Turner, 1967; Turner and Schechner, 1988)

Rationale I developed the use of TMOC during my M.Phil. studies (Winn, 1998). The identification of positive factors that might help the person to move forward from the crisis and also negative factors that may hold them in the reverberating crisis situation can help. The process allows them to take a step back from their situation. Paradoxically the distancing from their situation can give them the opportunity to view it differently. This leads to a problem-solving approach as opposed to feeling overwhelmed by their current difficulties. The 'components of crisis' part of the model contributes to the assessment. Together we looked at addressing deficits and building on strengths. Journeying through the model, either physically or on paper reinforces the overarching 'journeying towards recovery' theme of the dramatherapy sessions. It is not a recognised research method. It was used in the study as it is integrated in my clinical practice with veterans. Therefore it is important that the veterans' perceptions of whether it helped or hindered, and assisted in their journey toward recovery was integral to the research question. IPA was undertaken on the transcripts from the sessions to discern their views on this.

Session 4: Storymaking and text reading from Homer's Odyssey

The participant was invited at the close of the previous session to bring a story; poem; or object to share with me. This could have been something they had created or something that resonates with them.

In the second part of the session an extract from *Homer's Odyssey* (Armitage, 2010) (Appendix 1) was read out loud and the story and effect of exploring it was discussed.

Rationale I considered whether to be more directive and ask each participant to bring in a favourite fairy tale. Bettelheim (1976) advocates the use of fairy tales in psychotherapy, to mediate matters, which are not easily spoken of, yet may be fantasised about. His interpretations of fairy tales are heavily influenced by a Freudian approach and weighted towards the psychosexual interpretation. Bettelheim's rigid Freudian interpretations and rejection of myth as a guide in psychotherapy would have constrained the IPA to one perspective.

The invitation to bring in an object to illustrate a story or poem was a deliberately flexible brief. It gave each participant an opportunity to choose something that resonated with them. They might create something themselves, such as a piece of prose or share some story or poem that holds meaning for them.

This move into a creative mode provided a warm-up into the second part of the session where we shared a reading that I selected from the *Odyssey* play text. The pre-selection ensured consistency for the research analysis. It had been kept short. No participant had experienced reading from a play before. They also had the choice to read a part or listen to me reading all the parts. This approach can be useful for those who have difficulty reading or initially find the activity too anxiety-provoking. As with TMOC the transcript was analysed using IPA. I chose a modern day *Odyssey* text dramatised by Simon Armitage. Although it is still set in the same time as *Homer's Odyssey* and the language maintains the prose, it is easy to follow. Participants were also given an audio book of the play. The purpose of using the text is not for literary criticism but for an exploration of the experience of being a warrior. The use of a historic text distanced them from current conflict yet provided a common thread of the experience of life as a warrior.

Session 5: Text reading from Homer's Odyssey

The text reading (Appendix 1) followed on from that began in Session 4. The participant chose which role they wanted to read. The transcripts revealed the pacing of the readings, interspersed with discussion as each participant spontaneously commented on their identification with Odysseus's struggle. There were also comments on how this might help other veterans.

Rationale The participant could build on the last session's experience of text reading. Choosing which part to read contrasts with some therapy and life experiences where they

may have felt passive recipients. The discussion in addition to providing valuable insights and data for the research underlined the fact that their insights matter.

Once more the aspects that related to the research questions were examined using IPA.

Group sessions

Session 6: Text reading from Homer's Odyssey / Interviewing Odysseus

The group were invited to reflect together on the impact the *Odyssey* text was having. The participants were allocated roles to read from the play text (Appendix 1). They read parts and then re-read and discuss parts that affected them. They spoke of the relevance to the life of a warrior now.

After a break they were introduced to a scenario where a journalist is interviewing Odysseus. Jack elected to play Odysseus, Chris asked to be a member of the audience, Alan chose to play the interviewer but asked that I go first and then he would join in with questions. Everyone acted their respective roles and discussed the effect of the process once de-roled. The enactment and discussion were transcribed for the IPA.

Rationale The use of the play text and the opportunity to discuss their views of the reading from *Homer's Odyssey* from their individual sessions the week before, eased the transition into working as a group. They were given common ground to begin with. This awareness of commonalities assisted with the second part of the session, which explored the role of Odysseus further. Within the structure of the session there was flexibility that allows individuals to proceed at their own speed. This reduced the risk of provoking anxiety related reactions and allowed equilibrium to be restored.

Session 7: TMOC

The participants revisited the concepts of TMOC outlined in Session 3 in this chapter. This time they were given the option to sculpt a 3D model to walk through and recount their stories. Each participant took a turn to do this, with the others forming the audience and supporters. There was discussion about the effects of this process. In addition to the audio recording they decided they would like to film this. Jack has filming experience so took responsibility for setting up the video camera and filming. Both these data sources were used in the subsequent IPA.

Rationale The physical movement through TMOC allowed for exploration of embodiment and a chance to rehearse helpful muscle memory from their military lives.

This could assist them to overcome obstacles and reframe their stories. The group provided support and a physical presence in the model if requested. The person travelling through the model had the opportunity to take on the role of director and so be empowered rather than be a passive recipient of therapy. Both from a therapeutic and research perspective it gave information on any changes that may have occurred from the first experience of TMOC in Session 3 and the penultimate session.

Session 8: Dramatherapy – Speaking out / 6PSM

To mark the end of the dramatherapy sessions, this was held at another venue in a rural setting, which was familiar to the group. The venue was chosen by the participants to mark the end of the journey. This session focused on ending rituals.

In the ‘Speaking Out’ part of the session I wrote extracts from *Homer’s Odyssey* on pieces of paper (Appendix 1) these were then folded so the text was obscured. The participants were invited to pick a piece of paper then read out their text. Attention was paid to the embodiment of the character and any feelings, physical or psychological that might have been experienced as they read. After reflection in role, de-roling and reflection on the experience, there was a short break.

The second part of the session revisited 6PSM. The same construction was used as described above in Session 1. As each veteran participated their stories merged and they decided to share one large piece of paper, to illustrate their stories, taking turns to share their tales. BASIC Ph was applied to this part of the session for the individual participants in addition to the IPA, which was applied throughout.

The final part of the session was based on leave-taking. Alan, Jack and Chris created a mini totem each using things found in the natural environment. They were asked to hold in mind where they were on their journeys as they prepared for the ending of this stage. Time was then taken to reflect on the dramatherapy and the research process.

Finally at the close of the session we formed a circle and offered each other ‘gifts’ such as hope, to accompany us as we continued along our own paths.

Rationale In the first part of the session the extracts were taken from sections of text they were already familiar with. The words from Odysseus (Appendix 1) were selected by me, printed out and placed in a pot so that the participants drew them out. They were given the option of rejecting any reading they did not want to enact. Choice of taking on or rejecting roles was important, in terms of reinforcing ideas of empowerment and

decision-making. This is a low level way of enacting and embodying aspects of the role could try out. Before de-roling attention was paid to how holding that role in the body feels and any other resonances. It gave the participants a sense of testing their mastery of such a situation. The ensuing discussion provided further information about how they experienced the process.

The second part of the session was the revisiting of the 6PSM and assessment using the BASIC Ph provided information about any changes in coping styles. It also fitted with the closing of a circle of the process as this was used in the first session. The barn setting also provided a backdrop for the storytelling atmosphere.

The final part of the session acknowledged the journey we had been on and gave the opportunity to discuss the helpful and difficult parts of the dramatherapy journey. The ritual of 'gift' sharing and the final circle provided a symbolic ending.

4.5 Summary

The description of the participants' military backgrounds revealed similarities and differences in their service experience. They were all members of the British Armed Forces, although they served there at different times, all had experienced active service in Northern Ireland, all had received CBT in the past and all had formal diagnoses of PTSD. They had self-selected for the study, but were not initially aware who else was taking part in the research. When they identified one another they felt they shared enough in common as veterans suffering from the symptoms of PTSD to ask to join together in the dramatherapy research. The sessions' outline provides a reference for the flow of the eight dramatherapy sessions and a structure for collection of the data methods selected in Chapter 3. The structure also followed the process of a journey, thus acting as a reminder of the overall theme of journeying towards recovery. I included a guide to key dramatherapy techniques used in the fieldwork for readers who may not be familiar with those aspects of dramatherapy. I also provided my rationale for using them within the fieldwork. Chapter 5 describes the results from the qualitative and the quantitative results of the fieldwork. The transcript excerpts provide detailed information of the sessions' content.

Chapter 5 Signposts: Analysis and Interpretation of the Evidence

5.1 Introduction

In Chapter 3 I outlined my conceptual framework, reasons for choosing a mixed methods case study and the methodology itself, and in Chapter 4 I gave detail of the dramatherapy methods I used, fieldwork sessions' outline, clinical methods and rationales. This chapter presents the findings gleaned from these sessions. I have examined each case separately to reduce the risk that I will be influenced by findings from one case and look for familiar themes and patterns in the subsequent cases (J.A. Smith, Flowers and Larkin, 2009). This method also reduced the potential for missing emerging or novel themes (Hefferon and Gil-Rodriguez, 2011).

The IPA process has been applied to every session. The data produced 75 hours of transcripts, which have been examined using the detailed process outlined in Section 3.7, as recommended for IPA (Hefferon and Gil-Rodriguez, 2015; Shinebourne, 2011). The exploratory coding covered many aspects of the effects of psychological trauma (J.A. Smith, Flowers and Larkin, 2009), and the emerging themes were viewed through the lens of a dramatherapist (Breakwell, Smith and Wright, 2012). At that stage all emergent themes were captured using the visual representation of mindmaps. I used colour codes to capture emerging themes, for example anything related to the military, I coded purple and anything that may indicate a turning point was coded red (appendix 8). The themes were further refined where categories overlapped and by returning to the transcripts in an iterative process. Themes that did not relate to the research questions were only dropped at that stage. Sometime themes that seemed superfluous would take on further meaning and some that originally seemed important would recede. These reflected hot and cool cognitions (J.A. Smith and Etough, 2007). These were then clustered, and the content further refined using a thematic table. For the group sessions I examined the individual responses within the group. I then scrutinised the results for data relevant to the group process (M. Palmer et al., 2010). The IPA results are in a separate section for clarity (5.3). It is beyond the scope of this study to include all themes for discussion so only those relevant to the research questions were selected to take forward to that stage (J.A. Smith,

Flowers and Larkin, 2009). Samples of the emerging theme tables and samples of the mindmaps are in Appendix 8.

This chapter provides the platform for the synthesis of data and discussion of findings that follows in Chapter 6. The following sections survey the qualitative data results, 5.2 concerns the 6PSM graded using the BASIC Ph (Lahad, Schacham and Ayalon, 2013). 5.3 presents the IPA for both the individual and the group sessions. The IPA results take the form of superordinate themes and subordinate themes pertinent to the research questions. In Section 5.4 I examine the quantitative data results from the Clinical Outcomes Routine Evaluation-34 (CORE-34) and CORE-10 (Leach and Lucock, 2007; Barkham, et al., 2001), SWEMWBS scale and PCL-M checklist.

5.2 Qualitative data results

Session 1 Six Piece Storymaking (6PSM) and BASIC Ph

I have given details of the 6PSM structure and BASIC Ph grading scale in Chapter 4 (Figure 4.4).

ALAN

In Session 1 when I applied the BASIC Ph to 6PSM the areas that appeared to influence Alan most were his cognitive perceptions then affect followed by his rigid belief system. In the final session Alan's belief system has less prominence; there is also a reduction in the level of affect he experiences as he tells a story. There is an increase in his social functioning although he also expresses a negative social perception in his final session. He had a slight increase in his imaginative realm. There was a greater change in his cognitive processing.

Session	B	B-	A	A-	S	S-	I	I-	C	C-	Ph	Ph-
1	14	0	25	4	3	0	3	1	37	0	4	0
8	8	0	2	0	13	1	4	0	20	2	5	0

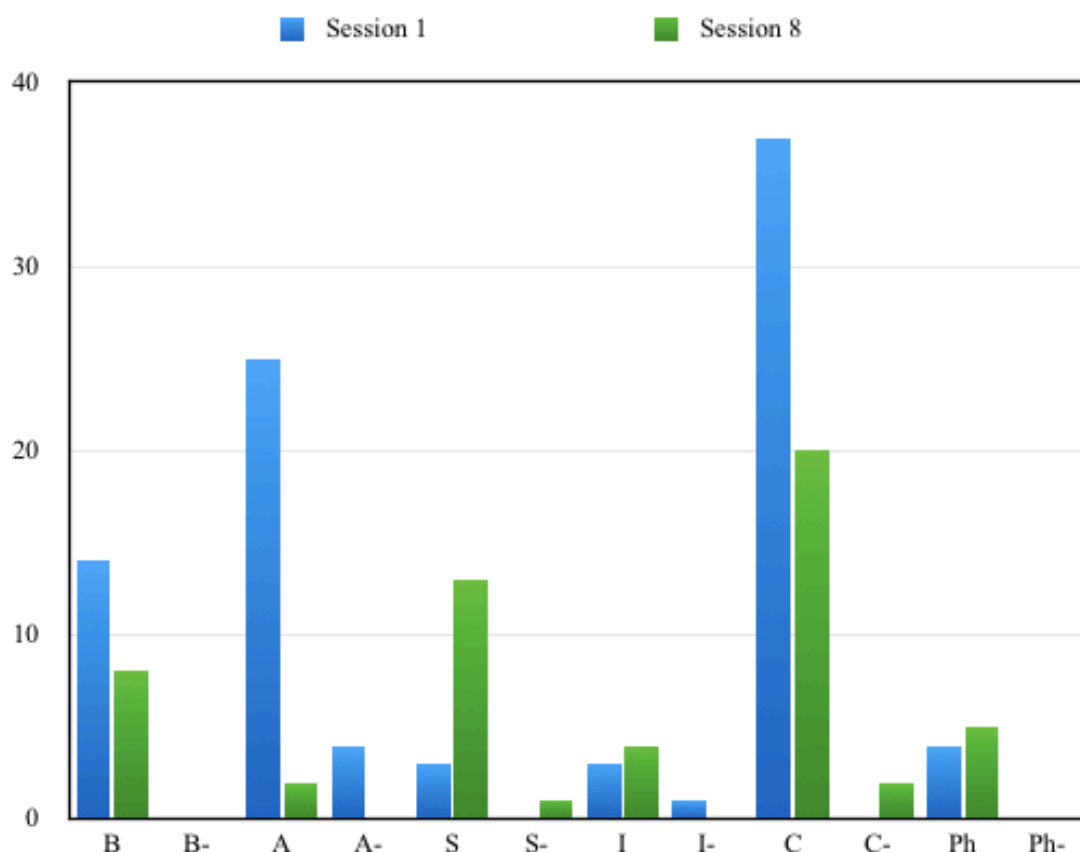


Figure 5.1 Alan's scoring on 6PSM (adapted from Lahad and Dent-Brown, 2011 p.130)

JACK

Jack demonstrated a firm belief system within his first session story making which showed some negative beliefs, by his final session this belief system was reduced in impact by over 50% and his negative constructs were not apparent. His level of affect had reduced by the last session. His social construct has risen in dominance and expresses both positive and negative social framing. The most marked rise in his area of expression was in his use of imagination as he created and recounted his story. This tied in with an increase in his

cognitive reasoning. His high scoring on positive cognitions reflected his ability to reframe his negative personal constructs through reasoning.

Session	B	B-	A	A-	S	S-	I	I-	C	C-	Ph	Ph-
1	14	5	11	3	3	1	6	3	1	3	2	2
8	6	0	2	0	14	17	45	1	22	2	1	1

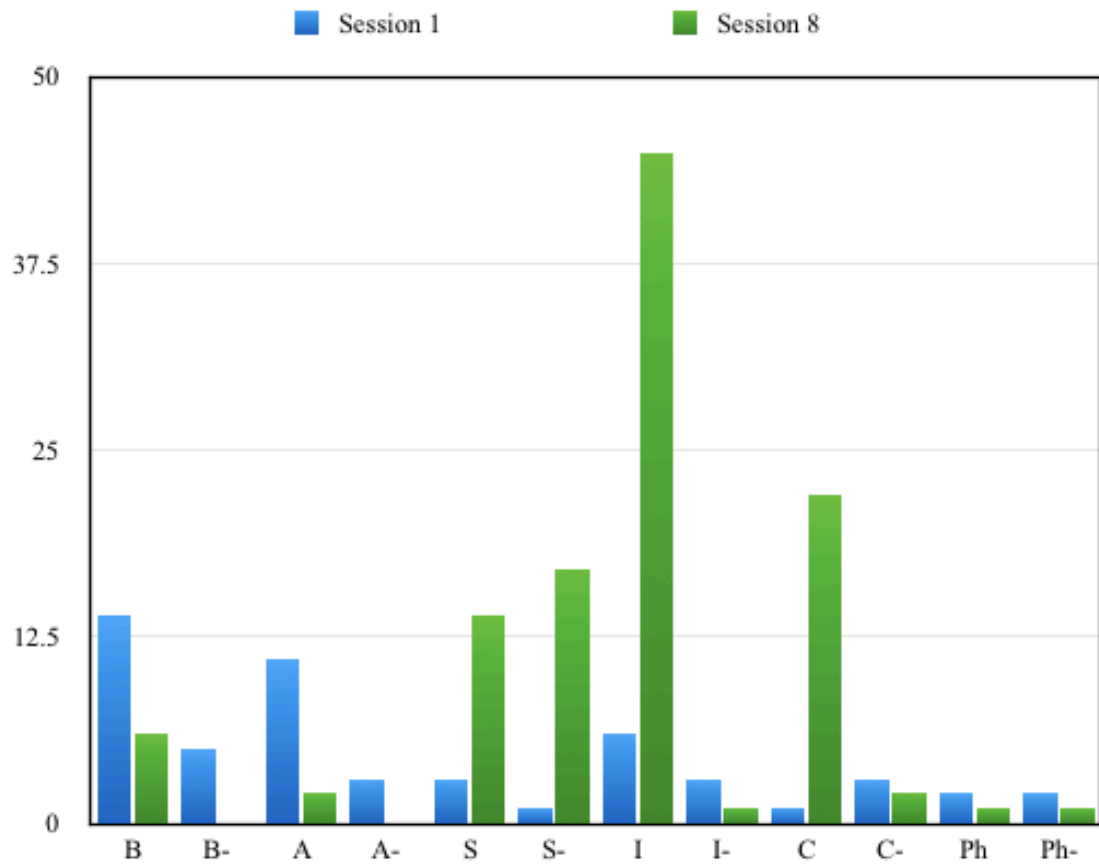


Figure 5.2 Jack's scoring on 6PSM (adapted from Lahad and Dent-Brown, 2011 p.130)

CHRIS

In his first session Chris's strength lay within the imaginative realm, however this was counterbalanced by the negative effect of his imagination; by the final session he expressed positive use of his imagination through his storymaking, with no negative imagination

traits emerging. In Session 1 his negative belief system was to the fore, in the final session he voiced no negative beliefs and displayed growth in expression of belief. Chris showed little affect as he made and told his story, although he dropped his negative expression of affect in his final story increasing the positive affect element. His social engagement within the story making had risen to its highest score by the final session and his negative social perception had risen by 1 point. His cognitive realm was barely engaged in Session 1 and was most apparent in negative cognitions. During the final story making it was apparent that he framed his story with positive cognitions and he had dropped his negative cognitions realm score from 16 to 1.

Session	B	B-	A	A-	S	S-	I	I-	C	C-	Ph	Ph-
1	2	4	1	1	3	1	6	3	1	3	2	2
8	12	0	2	0	19	2	11	0	16	1	2	1

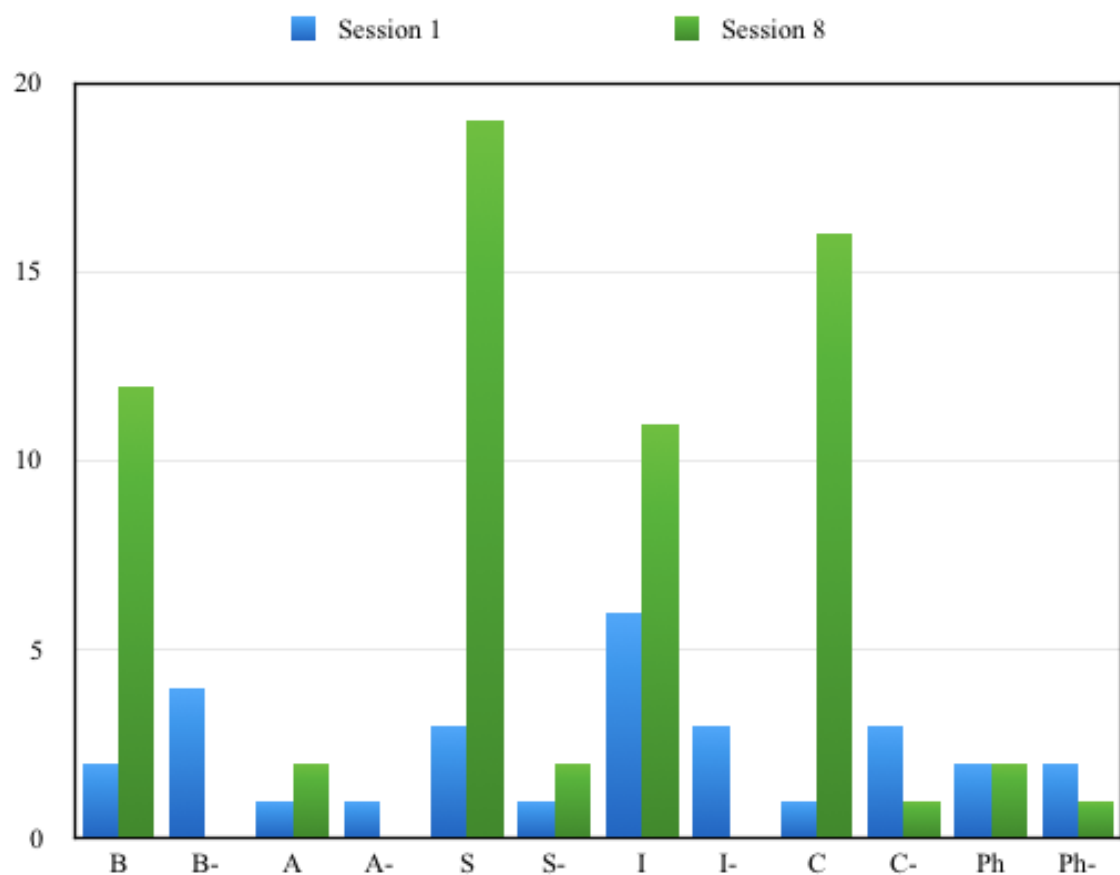


Figure 5.3 Chris's scoring on 6PSM (adapted from Lahad and Dent-Brown, 2011 p.130)

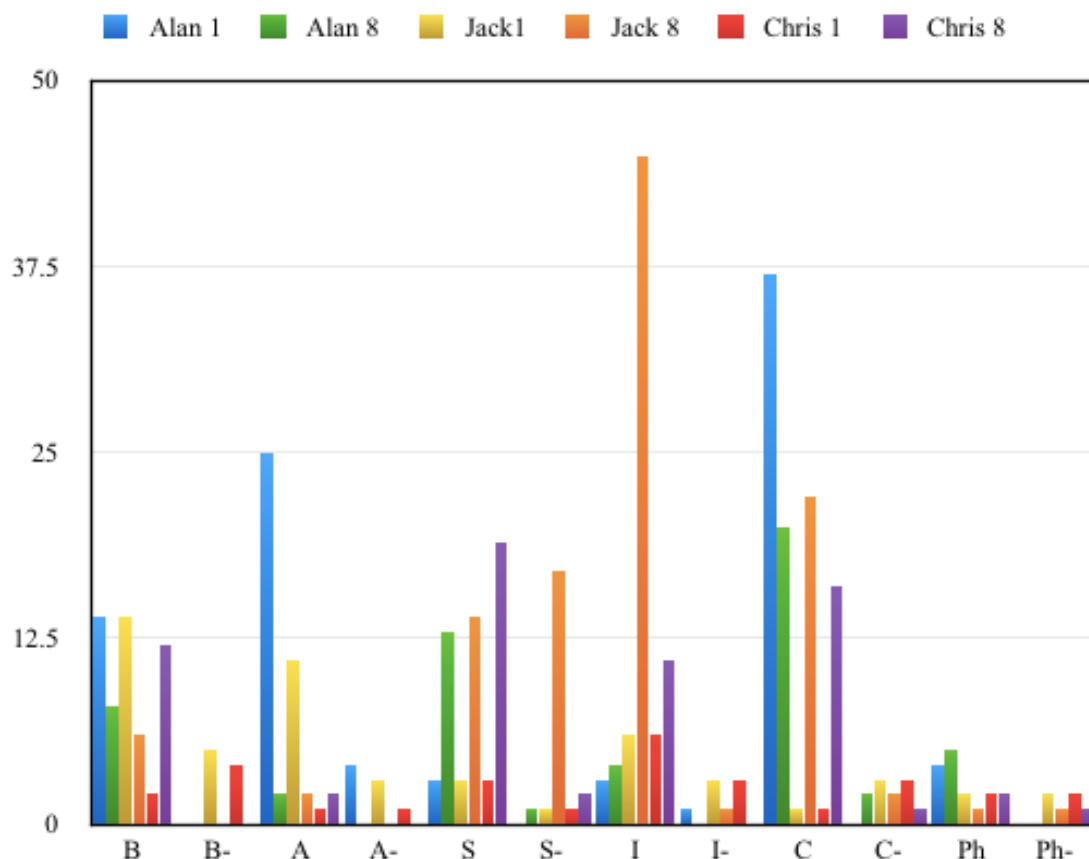


Figure 5.4 A comparison of all participant' scores – BASIC Ph Sessions 1 and 8

All participants

The 6PSMs were anchored by the drawings. The ensuing storytelling as the participants explained their stories provided rich material for the BASIC PH scoring.

Each participant showed a decrease in their [rigid] belief systems, with affect also reduced for Alan and Jack, and remaining low for Chris. The social domain and the use of imagination increased for all three, and Jack in particular entered into the imaginative realm. The cognitive domain increased for Jack and Chris and in the final session Alan's cognitive reasoning process diminished but moved closer to matching the others. Physicality was greater for Alan as an interweave in his story than for Jack and Chris.

5.3 IPA

IPA was applied to unstructured interviews (Interview Guide, Appendix 8) concerning the process and the content of each dramatherapy session. Extracts of session transcripts from Alan, Jack and Chris highlighted where their experiences converged or diverged. The individual mindmaps, tables and analysis that led to the selection of the superordinate

themes were rechecked against the transcripts to ensure I had stayed true to the participant's meaning (J.A. Smith, Flowers and Larkin, 2009). A sample excerpt from a transcript and data from an IPA analysis are found in Appendix 9.

The descriptive titles of the three superordinate themes (Figure 5.5) relate to the *Homer's Odyssey* text we read from. Alan, Jack and Chris all identified these words as summing up their experience. They were allocated after the coding process, ensuring that I did not search for themes to fit titles decided upon before analysing the transcripts. These superordinate themes and subordinate themes reflect the journeying process of the sessions. The clusters that contributed to the superordinate and subordinate themes are named from words used by the participants to describe their experiences of journeying in the dramatherapy sessions (Appendix 12). The *King of Oblivion* superordinate theme and subordinate themes reflected the participants' views relating to their backgrounds and personal life views emergent through the dramatherapy. *The man underneath this muddy suit* and subordinate themes reflected their responses to dramatherapy methods, both imaginative and externalised through EPR. Finally *Coming Home to Self* mapped the psychological, physical, social and spiritual journey towards recovery. The preparation phase utilised the discoveries, obstacles and possibilities they had expressed in the previous superordinate and subordinate themes. The reconnaissance phase marked the surveying of the terrain as they sought a way forward, Finally, marching on was the determination they expressed to move forward with their lives.

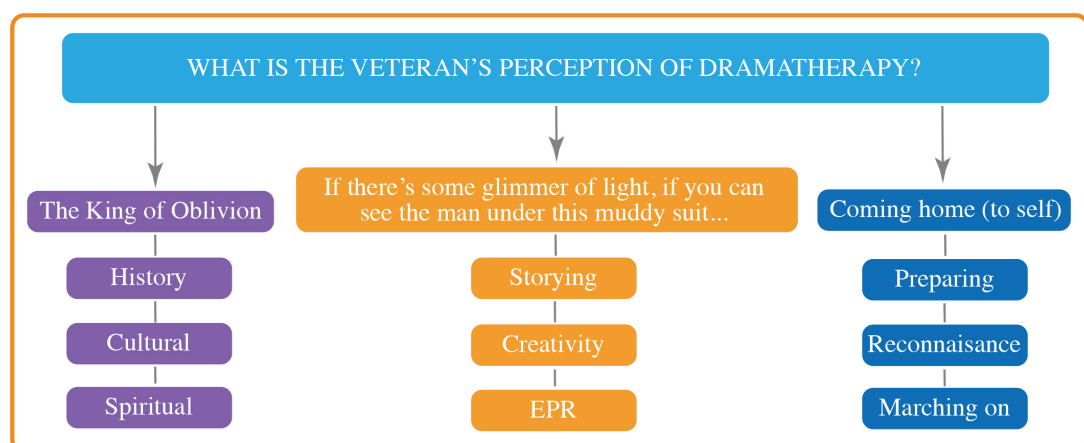


Figure 5.5 Superordinate themes and subordinate themes

The King of Oblivion was spontaneously emphasised in the text reading by each participant. It became a signaller of their individual life stories that had brought them to dramatherapy.

'If there's some glimmer of light, if you can see the man under this muddy suit...' This refers to the experiences that occurred during the dramatherapy process.

The longest part of the journey homecoming, adjusting to life outside of the military, was recognised as a major concern for all.

Individual sessions

Superordinate theme – The King of Oblivion

Each participant expressed this statement with emphasis as they related their personal histories.

ALAN

Alan spoke the phrase loudly, as in the stage direction *'I'm the King of Oblivion'*. His voice broke momentarily but he recovered and read to the end of the text section. He paused for three seconds

Yeah, that's quite deep that bit, but it's ermm, I mean straightaway, I do feel ermm a bit, not stressed at the moment, not bad, but just a little bit up here [points to temples] so I'll just have a little bit of a break. (Al. Session 5)

I agreed and we sat in silence for 30 seconds. Alan's role in the military meant he had to be extremely focused at times and part of his muscle memory involves his vision and temples. He has learnt that if he acknowledges this and just lets it go, rather than fighting against it, it will pass. He resumed, making good eye contact, so I was aware he was 'in the room.' (It is common for those suffering from PTSD to get so immersed in intense recall that they are in a different time and place).

...but straightaway, when you're reading it you are putting yourself in the image of, like I've been involved in, we've been involved in. As you know I've been in [area he served in] a number of times and it's the coming home that, when you're reading that.

Is that what is meant to happen? The images came straight in there. Um. And of course you see your family and that. (Al. Session 5).

Alan identified readily with the text. It provokes images. He has a deep sense of returning ‘not himself’. The overarching theme ‘*The King of Oblivion*’ was how he perceived himself.

JACK

Jack picked up straight away on the concept of oblivion:

...even the most modest people always like recognition and not just by other vets – I think anyone that’s personally suffered with anything, when you come back you need to be recognised. Um like when we got our medals we never got a medal ceremony, we had ‘em thrown at us - it was off you go, off you go, there’s no recognition! (J. Session 5, 786–791).

Jack spoke for others when Odysseus’ lack of ceremony on his return to Ithaca resonated. He became passionate in tone, with his personal memory of rejection coming to the surface. He acknowledged his was not an unusual experience. Oblivion in this context was the forgetfulness by others, which contrasts with their traumatic memories that they cannot forget.

CHRIS

Chris often has nervous vocal tics, they developed post-service. He has not been investigated for causation of the tics. Research studies do not show a direct link between PTSD and tics, which are thought to be associated with the basal ganglia area of the brain (Chouinard and Ford, 2000). It is suggested that nearby brain circuitry may become influenced by a malfunction in another area (Insel, 2010). The tics were not present when he read the part of Odysseus fluently. He made a gesture as if he was feeling the grains of sand, as suggested by Athena. He spoke of the King of Oblivion. This tapped into his own experience of what he describes as ‘heavy trances’.

...You do think that; the bit that triggers it – you think ‘yeah, I’ve done that’ it may not be a grain of sand but it’s just the feeling that it’s real ... (Chr. Session 5).

Unlike Alan and Jack, Chris thinks of oblivion from his own internalised perspective:

The reality of things, like when you hear things (tic) you've got to distinguish what the noises are to know if they're real or not so yeah, that's the same. Everything looks real, but it's not. It's like when I'm going back into battle and sometimes I'm in places I've never actually been and that's scary, then I've got to remember whether it's real or not. (Chr. Session 5).

When Chris is in that state of dissociation he is oblivious to his surroundings and time. He experiences being in battle. In the past he has lost several days. He felt that he understood the text of *Homer's Odyssey* from the outset. He has experienced others passing him by when he is in that state, mistakenly thinking he was drunk, or diagnosing him as suffering from schizophrenia, instead of looking at the whole picture. That is the situation where he identified with the King of Oblivion.

Theme 1: His[s]tory

When we enter the therapy space everyone brings their personal stories. A word, gesture or movement brings, however fleetingly, a memory to mind. Other times it is the very triggering of these experiences that helps to discern what is taking place and to be able to respond to the other.

ALAN

Alan relates that he had a happy childhood, set in the countryside, with loving parents. He is familiar with 'safe place visualisation', which was introduced in EMDR sessions two years before this study (Leeds and Shapiro, 2000; Shapiro and Maxfield, 2002). During the first 3 sessions of dramatherapy there were no significant mentions of childhood. However in the third session he alluded to a new 'minds-eye safe place' that he would tell me more about in the next session. The next session was programmed as an opportunity for the participants to create their own stories. This mention of what he was planning for the next session mirrored the discussion I would have during the closure phase of the dramatherapy sessions. It demonstrated that Alan was engaging with the process and directing. Embedded within that planning for Alan, is the military style of preparation for an exercise.

He began his story by linking back to the ‘path’ from Turner’s Model in the previous session.

I had to go up to my safe place yesterday and as we spoke about last week, that path. For some reason it got me out of that mood. I tried to work out why that part is so dominant in my mind ... the path, going along the path and getting out of it was absolutely wonderful. I will tell you my story about [where he lived] and the colours. (Al. Session 4).

Alan, in common with Chris and Jack, often related back to something that arose in a previous session. They all suffer with poor recent recall as a feature of their PTSD. It would seem that the multi-dimensional approach of dramatherapy gave them more ‘hooks’ that assist in recall. Alan’s story and safe place were based on a happy childhood memory. He recalled it was this memory, engaging all his senses, which had been a ‘safe place’ for him to call up in his mind, when he was involved in military operations. He had used this technique many years before being re-introduced to it through EMDR (Leeds and Shapiro, 2000; Shapiro and Maxfield, 2002). Despite the EMDR this core memory had been forgotten by him in recent years as intrusive traumatic memories buried it deep within. His reconnections with that early childhood memory freed up other positive memories, that came to the fore through his storytelling. The recall appeared to be sparked by his imagination recreating the scene.

He told of learning something from his 12-year-old self. It may be that I saw a glimpse of that 12 year old as the tempo changed, and he spoke of the military:

They didn’t teach me my skills; I gave them mine ... That’s cheesed me off. I’ve given my life, my childhood when I think about it ... upsetting, yeah I gave them more than they gave me ... I gave them something and they took that away ...(Al. Session 4).

In that statement he expressed anger and grief both in statement and tone. It was the first time he had related his current state back to losing to the military something of his childhood. The distancing he experienced through storytelling altered his perspective.

I had a decent upbringing, a good mum and dad, safe and secure ... A divide between that and what I had to go through. I have a fear of something unknown ... I am still running from that! ... (Al. Session 4)

Alan had remarked he had learnt something from his 12 year old self during his story making. His comments suggested he had found words to express a different view of his life.

JACK

In contrast Jack had no such secure childhood to refer back to. He had attempted to replace his insecure attachment as a child when he joined the military family. He spent his formative years in Germany, where he described his paid carer as bringing him up with a wealth of folk tales. These tales continue to influence his life as he seeks to find a way forward. In the 6PSM he used Rumpelstiltskin as his hero:

... it was a fair deal that they all agreed on and then when it came time for him [Rumpelstiltskin] to get what he wanted they realised they couldn't and they cheated him out of it – it reflects on me a lot, and um I dunno, it's a weird one. I do empathise with him and I sort of understand and I feel how unfair it is, but the bit that really plays on my mind is that it's so unfair to him they didn't stick to their deal yet everybody celebrates it. They lied and cheated to get what they wanted but everyone backs them. (J. session 1, 52)

Jack recognised this as the first time he was aware of 'a massive injustice' (J. Session 1, 46). He tried to explain this to adults and expressed some irritation that they did not understand his way of looking at matters. He recognised that the frustration he experienced has continued to the present time. Although he described a difficult childhood with his mother he aligned with her on this matter, illustrating his ambivalence:

It's just something I remembered as a kid, and my mum also was very good at spotting hypocrisy, seeing through a lie. (J. Session 1, 83–85).

Despite describing himself as uneducated Jack displayed a thirst for knowledge. He immersed himself in texts for preparation for the dramatherapy and expressed enjoyment of the challenge. This also reflected his military attitude where nothing should be carried

out half-heartedly. Jack came to life as he talked about discoveries he has made and shared with others. He made links to how his earlier experiences influence how he responds to situations now. He described a rage, which lies deep within and was there from childhood. The flip side of this was his knowledge and hunger to explore these issues provided respite from his intrusive memories and physical pain. The inner rage had set him a quest to make sense of what he is experiencing. His earlier experience of exploitation and neglect mixed with that rage has forged an iron determination to move forward. He described himself as ‘iron-fisted.’ (J. Session 1, 185).

CHRIS

Chris brought with him a history that ticked the boxes for every category of child abuse. He gets lost for words and has vocal tics that communicate a volume. He was unable to tell his story through the 6PSM in the first session. He explained: *‘I never had stories as a child, I immediately think about my monsters’* (Chr. session1).

I responded to him that imagination could be used to introduce good things, and spoke briefly of Fantastic Reality (Lahad and Doron, 2010). Chris became animated and enthused. He spoke fluently.

It will be much easier to tell a story about someone I don’t know. I write poetry and really enjoy playing with my children. I’ve got some ideas now. Can I take it away and work on it for the next session? (Chr. Session 1)

Chris showed the need to distance from his intrusive images. He was keen to explain what he is good at. He has some fear that because of his own experiences in childhood he will not be seen as a caring parent. He was demonstrating problem solving, offering a way he could complete the task. Often his life has involved not being listened to, when he tried to verbalise the abuse he was experiencing; when he sought help; when he tried to find his way through things. He has a need to reflect on things, simultaneously guarding against his ‘monsters’. I considered these matters and felt it important that I agreed with his solution rather than reject it.

The theme of being a man, trapped within a man, trapped inside a boy, sometimes described through the metaphor of a hermit crab, but most usually illustrated by the use of Russian

dolls, was built on through the sessions.

I'll tell you who that is – a boy, inside a boy, inside a man, inside a man and you can see how trapped that is, so first of all I've got to get the real me out, the me now [tic], see what I mean, I've got to get the real me out, then there's all these others – that's the me, so I've got to get out of this one, and this is the heavy one. (Chr. Session 2)

The person present in the room was often that vulnerable boy, the boy oppressed by 'the heavy one,' who needed sensitive nurturing approaches. This was not the battle-hardened warrior that some people might expect to be present.

Chris shared his poem *The Twisted Oak* (Appendix 12). He spoke of the tree, trapped in the middle, protected but starved of nourishment, living off stuff that fell to the ground; he revealed the sense of isolation in a crowd. There was also that darkness deep within a forest. He changed from the tree metaphor to 'we're rotten, some of us'. This was a stark metaphor for his childhood experiences of literal starvation and the self-blame he has carried with him.

They survive, they learn to survive and that's how they do it, but that shouldn't be the way, should it, every tree should be growing up to be beautiful but we're not like that, we're rotten some of us. (Chr. Session 4)

Later on he reflected:

... they suffer to protect us so in a sense that's why we are the tree (tic) cos we might suffer sometimes to protect other things, other people - and how do you give a tree a break, that's the problem, how do you look after a tree after that, it's there to help us. You have to treat it now and again, and feed it, and make sure its happy - if you don't, and you leave it, it just falls to bits [...] and that's just what they do, they just deteriorate and try to survive, they suck whatever they can, and that's me, I suck in life as much as I can to keep surviving. (Chr. Session 4).

Chris recognised the need for nourishment, if not it [he] just falls to bits. He moved beyond that to a notion of being happy. There was a sense that this should be provided from an external source as recognition of the service that had been provided. There was desperateness in what has to be done to survive – sucking it in – whatever is given, but an

emphasis that without assistance it falls apart.

These extracts about the developmental themes showed, Alan, Jack and Chris have divergent as well as convergent experiences. These experiences, or in therapeutic terms ‘personal constructs’, their his[s]tories were embodied when they entered the therapy space. They did not metaphorically leave their boots at the door. One size does not fit all, even in the research process. Chris has a tendency to dissociate so this needed to be taken into account, to ensure he was grounded when he left the session. Jack’s rage is never far from the surface, so exploration of risk was to the fore at times. Alan experiences muscle memory that could trigger flashbacks. Their uniting culture was their military service.

Theme 2: Cultural

The personal stories influence and are influenced by a cultural lens. In particular, and for the purpose of this study, the focus was on their military and civilian perspectives.

ALAN

Alan often shared his perspective in a temporal, factual, geographically situated way. He gave concise measurements and map references. He used technical detail and military terminology. I am familiar with this language so he did not have to translate.

...it was the Saracen [armoured vehicle], it was the first time when I ever saw anybody get injured because up until then it was low velocity bullets and we then got issued with [type of weaponry] and what was fired as us went through both sides of this armoured pig ... hurt one of the chaps in it, in fact the two of the chaps in it, not seriously thank goodness but it, now of course it’s not armoured Saracens or pigs as we called them all those years ago but they’re a lot, lot better vehicles and everybody’s safe in them. (Al. Session 2)

He emphasised the word ‘safe’. However he stayed in ‘military mode’ in his reporting style. His body posture was alert, upright. It felt like a military briefing. He carried that mode forward to his life as a civilian. He described a recent event:

... reference to the boat I said we went into the tunnel and it’s 522 yards long. You are going into complete darkness and that doesn’t bother me at all, you couldn’t even see the end of the tunnel ... it doesn’t bother me at all, it when you do see the end of the

tunnel it so bright, like a little light that doesn't bother me. I'm more scared, not going into the tunnel, it's coming out of it, it's what's going to be at the end of it.

When we did come out of the end of it, it was quite bright and I saw one of the nicest sights I've ever seen. From an army pill-box Second World War ... 50 yards past that at 10 o'clock there were a couple of boxing hares and behind that with these lovely golden hills and this copse about 500 metres to the right. (Al. Session 3)

The detailed information that reflected his military mode. He insisted he was not bothered by being in the dark in a tunnel, after all, this was something he was trained for, he had survived those situations in a measured and controlled way. He would already have looked at maps and be thoroughly prepared for the journey, hence his ability to relate the length of the tunnel. The scary thing for him was what awaited him. His repetition of not being bothered by the darkness could have been part of his preparedness to face what he was anticipating might lay ahead when he came out into the open. The repetition of the phrase in a confident manner suggested a mantra to reinforce his resolve. The years of experience of a soldier would have taught him to focus on moving forward. This time he was pleasantly surprised. This was reflected in his change of body language. The military and civilian aspects of his personality were interweaved in his story. He has spoken about his childhood appreciation and observation of nature. It was the attention to detail, the ability to read his surroundings in such depth that kept him alive when in the military. He then drew parallels with his military experience. He made a distinction between then and 'civvy street'. He saw that the hyper-vigilance does not need to be relentless.

In the following storymaking session he brought in a small posy of flowers as an artefact for his story. He spoke about his military service.

I don't care what anyone says, it's impossible, you ache, can't get comfortable, you feel miserable, you feel sick, you don't have proper food. What kept me sane was those simple things, but of course I never really realised until we got into it last week .. those colours [gesturing to the posy] kept me sane. (Al. Session 4)

A childhood, civilian experience had given him strength, resilience, to maintain his sanity, focusing on the other. The other side of this aptitude for strong visual memory also

contributed to the traumatic imagery that now haunts him in the unbidden flashbacks. He had reported feeling angry and tense at the beginning of the session, but he now remarked:

At the moment I feel quite chilled, I feel very chilled out...I know it was that path going on from last week ... I knew straight away that colours have always been an important part ... I can actually see them, I can appreciate they are real ... but then it all gets tangled up together. (Al. Session 4).

The colours that brought him relief can also drag him back to the unpleasant memories, it was as if the two were entwined just as the military and civilian aspects of the personality are. *‘There is no separation there. Now we’ve talked about it here, it may be different’* (Al. Session 4).

Alan was expressing more confidence and played with the metaphor and possibilities. He was able to contemplate that things could change.

When Alan was rounding up at the end of the session he said: *‘I’m clearing that shelf, getting us through that tunnel, I can do that, can I?’* (Al. Session 4).

He was talking in a normal voice and was oriented in time and space, yet there was an echo of the military in his response. The word ‘shelf’ referred to a metaphor he had been playing with. ‘Clearing’ could have been interpreted in a civilian context that he was seeking clarity but it is a military term and action, where some will go ahead and ensure it is safe. Alan was taking the lead, being protective, getting us through. The permission-seeking was different from before, when it was asked with a sound of urgency and underlined the importance of getting it right – in a military setting, often a matter of life or death. Now it was more rhetorical in nature. His body language was upright and confident. Alan demonstrated that he could tap into resources from his time in military service. The distance provided by using metaphor in his exploration stopped the *‘all tangled up together’* he referred to earlier in the session. It led to his reflection *‘Now we’ve talked about it here, it may be different.’* He acknowledged he felt different and this was shown in his change in physicality. This suggested some determination as he moved forward in the session and in his journey towards recovery.

JACK

Jack reflected on his communiwell and referred to life in military service:

Yeah it was cold, but both ways it was good 'cos you never mind what you've got to do – you're cold like a robot, you just do it – you think that's the way the world is, you just put up with it and get on with it. (J. Session 2, 107–109)

He then went back to how he perceives himself growing up:

I realise how cold and narrow-minded and intolerant, a lot of things I used to be.

[L. Right, okay, so that seems to be quite a disparaging way of describing your younger self – is that how you feel about yourself?]

Yeah, yeah, brutal – I really was – I never had the physical relationship with any of me family – I was never a hugger or anything like that. (J. Session 2, 114–119).

He acknowledged his[s]tory of violence and yet had moved to the past tense as he explained the culture he grew up in and further experienced in the military. This shift in his cultural values was alluded to earlier on in his reflection, when he referred to a conversation with someone close to him:

I'm broke and I said can you not see the comparison? You can't just give up 'cos you're broke – I just don't get it – it takes an injury or something bad to happen to make you think differently – as you get older you realise things like that. (J. Session 2, 101–104).

I don't break people's barriers at all so I don't expect mine to be broken you know. I don't know where that comes from, I'm just really, really cold like that; (J. Session 2, 120–122).

it was worth saying that - if it was someone I didn't care about, but this was different, I didn't want to break that bridge, I've broke too many bridges. (J. Session 2, 422–424).

never given a break – unfairness, injustice (J. Session 3, 60–61).

...the brutality of the training and the way they break you and everything else – it puts the fear and discipline in you... (J. Session 3, 212–213)

...point with PTSD in your life going wrong, changing, and the points where it meets, then BANG, then you get your belief system can completely break - you fight the fight and go straight down and you crumble, and I think maybe it just breaks enough to make you look at things differently, away from them rules. (J. Session 4, 198-201).

One bit that really resonates with me is when he gets shipwrecked – he comes back covered in mud, a broken man. I think I saw myself there when I was discharged – I had nothing. (J. Session 6, 298-300)

Jack's sessions were scattered with references to being broken but these were tempered with assertions of not giving up, battling through, there seemed to be resilience instilled by his military training that has got him over obstacles he encounters in civilian life. He is in constant physical pain from his injuries which also feeds into his mental anguish, yet he stated this [dramatherapy] '*make[s] you think differently.*' His shift in outlook suggested PTG (Dekel, Mandl and Solomon, 2011; O'Rourke, Tallman and Altmaier, 2008).

CHRIS

Chris has constructed survival strategies since infancy. These have both protected and isolated him. He has a sense that the 'real him' is buried within, but that is the one he refers to as 'heavy'. He dropped his voice as he said this. It is certainly a heavy burden for a boy to carry. He extended this metaphor further, mixing metaphor with reality.

I had to grow up very quick – I didn't really grow up I had to put the man's suit on, I – when I went to the boys home I had my dad's trousers on, they were up under my armpits d'you know what I mean? So – yeah they couldn't turn me into a boy again – the boys' home, they just made me feel comfortable for what I was – they couldn't change it, they made me believe I could wear my normal clothes that fitted me, I could sort of be that size - yeah there's that about it they just put me in a safer place I s'pose, in me shell, until I joined the Army which then jumped into another shell – see what I'm saying, so the boy inside the boy inside the man inside the man - that's perfect. (Chr. Session 3)

Chris related the passage above fluently. He had to 'put his dad's trousers on', as he had never been given his own clothes. He stated he had to grow up quick and then

reflected he didn't really grow up. He considered he had kind treatment in the boys' home. *'Yeah, they couldn't turn me into a boy again, they made me comfortable for what I was.'* (Chr. Session 3).

Chris carries with him a sense of not deserving better. His voice dropped to a whisper as he related the above. He showed no outward sign of emotion as he sought to find the words, however no tics occur. It suggested that there is a mismatch between outward appearance and how he feels inside his shell. He expressed satisfaction with the metaphor he has used to describe his story. His lack of emotion as he related his story, suggested the impact the abuse had on his emotional development, when he had few words to express his experience and when he tried, he was not listened to.

In terms of cultural influences, civilian and military, his experiences of survival seemed tangled up rather than just entwined. There was the toughness and resilience of the warrior, the outward persona he presents when able. However he referred to the man inside the boy, the civilian character within and closer to the surface was the lost boy. (When he described this he used the Russian dolls and it was the largest external doll that he designated as the boy). The metaphor provided a distancing from the trauma experienced in childhood and in the Army, yet demonstrated powerfully his disempowerment.

Theme 3: Spiritual

ALAN

In 6PSM Alan opted for a factual hero, a person he was close to, who died as a result of a battlefield injury.

One of the bravest people I have ever known ... It is very important to me that I remember it and that I can tell other people. I'm doing my bit for his memory. ... And that to me is very, very important. Very important ... I would very much liked to have been with him when he actually did pass away. I wasn't allowed to be with him so I've always been a bit cheated out of that. But of course I do say my prayers. I say 'God bless you [Alan names person] I miss you very much' and as you know I will go to my place. I do like churchyards. Wherever I am at 11 o'clock on Armistice Day it's my thing to walk 7 miles to put his name on a cross and just plant it by the Cenotaph or War Memorial in that church. (Al. Session 1)

This loss is so important to him that he brought it to the research, knowing a record would be made. I also became a witness to his memory, of the event and person [he gave more details, which I have not included for ethical reasons]. At the time Alan was serving in another theatre of war so had been unable to be there to assist or protect his friend. The question of ‘why him, not me?’ hangs in the air, many years on. Survivor guilt is listed as one of the possible criterion for PTSD (DSM-IV-TR, 2000). Although Alan was not alongside the person when he was fatally injured, he now keeps his memory alive by ‘doing his bit.’

JACK

In Session 4 Jack expressed the enjoyment he has had in preparing for the session, including comparing Dante’s *Inferno* and *Divine Comedy*. He noted that as well as taking his mind off his traumatic memories he has better recall when absorbed in story; it also helped him recall history he had learnt as a child. Jack then became thoughtful and discussed veterans who have committed suicide:

Um, that's why I said about religion, I'm very open-minded about it, whatever the culture's got to say and I do believe that for warriors, I prefer the idea of Valhalla

[L. OK can you explain that a bit?]

Obviously it's Nordic and the Vikings believed it and a lot of the Scandinavians, that if you die heroically or die fighting or as a warrior you go to Valhalla. Which to me, in my mind, in laymen's terms, is like this massive Veterans' Centre, so you don't only just go to heaven to fit in – you're going to somewhere that's like Combat Stress [A UK Veterans' Treatment Centre] to help – it helps because you fought in the past and then I was thinking about Christianity saying about suicide, blah, blah, blah. In Valhalla he rewards all warriors regardless of how they perished.

(J. Session 4, 121–126)

Jack’s knowledge of other cultures’ tales gained from childhood has provided a foundation for his present sense making. As someone who has often felt he does not fit in he derives comfort from the possibility of Valhalla. Jack was able to discuss his deeply held personal

beliefs that have been rekindled as he tried to make sense of texts he wanted to bring to his storymaking session.

'Cos they got detonated afterwards, it doesn't mean they didn't die a warrior so then I think about the guys who killed themselves, they've been in action and served- they'll probably go there as well.

(J. Session 4, 129-131)

Jack referred to veterans who have committed suicide as having detonated themselves; the image of detonation fits the impact of the violent way they died. He sees Valhalla as being a place that will embrace all warriors. He expressed empathy for those who have committed suicide. He moved from an informative, explanatory style to that of compassion. The preparation for the session and topic were of his volition. It indicated his commitment to the dramatherapy process and was also a mark of his military training, where preparation is considered so important.

CHRIS

Chris has experienced loss of self and trust. His feelings of abandonment – as a child; in the military, when his services were no longer required; as a veteran, when he recently experienced having five Community Psychiatric Nurses in under a year – impact on his belief system. When he was text-reading from *Homer's Odyssey* he drew a parallel with the gods and the 'powers that be' in the Army:

'Cos they play with us – they go in there, they go in there and they go in there, d'you know what I mean, look at the World Wars. We're gonna send them over there and we're gonna send them over there – you're not going over there yourself? No we got toy soldiers to do that – we've got our soldiers, we've got our toys, they're replaceable, just go and buy another one, that's what the gods did in that respect, they kept playing with our feelings and our – see Athena sort of did that but she did it in a nice way – 'cos she could see what was happening and wanted to try a different way. (Chr. Session 5).

Chris was fluent in his recall and précising of the text. There was no ticcing. He entwined his own situation with that of Odysseus. Through this he expressed his anger at being

regarded expendable, perhaps there was also an echo of being treated as a sexual object in childhood and a resonance of the abuse of power he experienced again in military service. He then spoke of the gods abandoning Odysseus. He understood the nightmares that occur in the dark. He emphasised this by referring to ‘*extra darkness*’:

...at the end, the gods leave them and give them extra darkness – to have their nightmare because he’s killed them. ‘Cos he said don’t make it light so quick, keep it dark. (Chr. Session 5).

In contrast to Alan and Jack, Chris did not express overt spirituality, what pervaded his commentary was hope. There was an inner spirituality, a seeking of something more. He corrected himself from ‘*pretend there’s hope*’ to ‘*I try and believe there’s hope*’:

I dream how it could be, so perhaps there’s a gap there somewhere – remember I said about the tunnel – there is light at the end of the tunnel but I can’t see it yet, so there’s a lot of turns – normally a tunnel’s straight down and then you see a light at the end of it – well my tunnel goes like that – and I haven’t got round them bends – I know it’s there somewhere, I just don’t know where so I’m hoping, know what I mean, I’m hoping I’m on the right path – so I try and pretend that there’s hope, or I try and believe there’s hope. I won’t say pretend, I try and believe there’s hope. (Chr. Session 5).

Through his reflection Chris recognised his ‘*inner strength*’. He has faith that there is light at the end of his labyrinth of tunnels.

Superordinate Theme: ‘If there’s some glimmer of light, if you can see the man under this muddy suit ...’

Consideration to the elements described in ‘The King of Oblivion’ assisted me as the researcher/dramatherapist to see the man. It gives the participants an opportunity to discover what may be buried under their cloak of trauma. Those elements would infuse the sessions, challenging and aiding us as we sought to journey and make sense of that travelling.

Theme 1: Storying

This incorporated the use of fiction, truth, metaphor and re-storying (reframing).

ALAN

Alan readily engaged with the communiwell as he told his story. When he moved from relating his military symbols to those that represented his civilian life, he sighed, visibly relaxed, and changed his tone to a softer and more animated one. He compared his life with that of a plastic badger he placed on the communiwell:

...very secretive, comes out at night, does a lot of work at night, early start, early finish, I don't see many people and that's it... absolutely shattered, like a badger I could just find somewhere to curl up and sleep. (Al. Session 2)

He shifted his talk of the badger's habits to his own. He identified strongly with the badger and at the time a badger cull was taking place in area. He went into details of his physical safe place, moving from past to present, contrasting with his normal very precise chronological ordering. I noticed a change in how his body posture altered, I invited him to comment on that.

Well, the curling up gives security and safety. A badger has certain traits and characteristics I can go along with. If I venture out of my safe zones, I feel apprehensive, not scared, apprehensive, and I'm going to sniff around until I felt at home.

Alan emphasised the difference between being scared and being apprehensive. I wondered if 'sniffing round' equated with testing the ground and also applied to the dramatherapy research. I reintroduced the notion of the badger's story and his family and asked if anything came to mind – if Alan was thinking about a tale? I was deliberately using distancing through his metaphor. Alan followed through the metaphor:

Well, if the badger kept off busy main roads he could look after the young more, a bit more protective towards his family, his young 'uns, he might be a happier parent.

Alan had spoken in other sessions about his sadness of not being there to see his children grow up. Even when not on operations, he did not feel emotionally there for them. He was equating taking care of the 'young 'uns' with the possibility of being happier as a parent.

JACK

In his individual 6PSM Jack elected to use Rumpelstiltskin as his heroic character. He said that since hearing the story as a child in Germany he had seen the injustice of the way Rumpelstiltskin had been tricked. He identified with the character as being misunderstood and bullied. This resonated with some of Jack's own experiences:

Yeah, obviously as soon as you come up with the story model – it's one that's always sat at the back of my head 'cos I feel I'm the only one sees it that way. It was hard to put what's going to stop him. I can tell you straight off it was difficult to try and think what are the stumbling blocks – I see the whole picture but trying to pick the individual details was a bit difficult but in main terms it was just a case of digging in my head and trying to find them.

(J. Session 1, 114–120)

He felt isolated in his interpretation. He also talked in terms of seeing the whole picture. Within the dramatherapy sessions he showed a strong inclination to thinking in pictures. This ability to favour imagery led to creativity. It also conjured up pictures from his military service that haunt his dreams as he expressed in the poem he wrote for Session 7 (Appendix 12).

*I have returned home and away from the dread
The only thing that scares me is going to bed.*

(J. Session 7, 367–368)

Jack had completed his 6PSM rapidly and enthusiastically. Yet it had been something that had been in his mind since childhood. He has marked memory recall difficulties, however this way of working had given him a direct line to that story. He was animated when recounting it.

I think I was lucky, 'cos if you'd told me six years ago you'd be interested in writing and putting your opinion forward, I would have said no, not at all, can't do that, it was only since I got ill, and a lot of it came from pure isolation, trying not to dwell on the bad stuff but also through life experience and getting older it gave me another view which I'd probably never paid attention to before but I do now. I look at a lot of the old folklore stuff and that because I don't think we should ever forget the guidelines. (J. Session 1, 123–130)

Jack identified that something positive, which he had not thought possible, has emerged from the isolation he has experienced due to his physical and psychological injuries. He has drawn on long-remembered tales and explored these further through the internet to gain a different perspective. His personal constructs are influenced through his understanding of folklore. His 6PSM and other dramatherapy sessions have drawn his attention to his PTG. As demonstrated in the excerpts from the sessions he was beginning to see new possibilities, he was exploring spiritual issues in his recall of folk tales and showing an appreciation for life. (Tedeschi and Calhoun, 2004).

Talking like this about stuff like this is some of the best stuff I can do, I feel so passionate about it. It's helped to be able to do this, a lot, and not the bad stuff.

(J. Session 1, 250–252)

He expressed further the advantages he felt of participating in the dramatherapy session:

There's not been any intrusive ideas, even about what I've said whereas talking about life, I get hit a lot with thoughts and images. When I talk about this it's a chance to put your side across, which steers me away from a lot of negative thinking.

(J. Session 1, 255–258)

Paradoxically Jack had been able to explore the effect his experiences has had on his life and make links. In the assessment process he provided ample information. Yet in telling the story he was able to harness his creativity to look forward. He commented on this hope:

It's something I'm interested in, not only my own personal need for writing it, I just like the way it is - structure, conversation. I like working that out, it's help me get towards other things, obviously the information's in it too. I'm excited yeah.

(J. Session 1, 267–270)

I offered Jack the copy of his 6PSM; he declined, saying he was confident he knew it back to front. He found the structure and imagery assisted with recall.

Jack hopes to gain work in film production and so he was also learning approaches that may help him in his journey towards recovery. He had not previously experienced therapy that was not directly trauma-focused CBT. He found using the creative process of dramatherapy gave an opportunity to show 'the man under this muddy suit'.

CHRIS

Chris naturally used metaphor and imagery in his storymaking. He moved swiftly through time and between reality and story. When he was working on his communiwell he commented on his self-imposed prison and explained:

... recovery to me is about how you can deal with the problem – it's not about put a bandage on it and it'll be all better in the morning – not about a broken leg getting better – it's about recovering slowly, being able to manage it – um someone show me how to put the plasters on and I'll keep putting them on. If I feel they're gonna work, I'll keep putting them on and maybe someone can take away some of the dirt, then it'll be easier to manage. If I can manage it then perhaps I'll get one step ahead where I can slowly chink away at it with a chisel – if someone gives me a chisel I'll just chip away, I'll just keep going and there's all these walls and I'm tired and the chisel's worn out.

(Chr. Session 2)

During this session Chris reflected on whether he should report the abuse he suffered as a child. His emphasis was about taking it slowly but also how tiring it was to try and find his way out of his prison. He had shifted from his passivity in his first session, wishing someone could take his traumatic memories away from him to thinking how he could play

an active part in his recovery: ‘*someone show me how to put the plasters on and I’ll keep putting them on*’ ‘*– if someone gives me a chisel I’ll just chip away.*’

Later Chris wondered whether he does not get help because he has invisible stabilisers on his bike so people think he is coping, he then became thoughtful.

I’m too scared to take my stabilisers off – there you go – it’s not I can’t, I’m too scared to. I won’t take them off yet – I need that reassurance – I need to go back to that childhood in a way and change me – maybe, I don’t know.

[L: Right, to build up?]

Build up your childhood again – the bits that are missing and to be able to understand those bits, then maybe I can move on to the next stage. (Chr. Session 2)

In this metaphor of a child’s bike with stabilisers, he was using an example of something he never experienced, yet common for so many children, that first bike with stabilisers, and help to find balance. Being labelled as unstable or unbalanced was also something he had experienced in adulthood.

In the next session Chris continued to build on his metaphors when he worked through TMOC. He used it to explore a current family situation and was hoping his youngest son would understand him eventually as his teenage sons do.

So if one’s [one of his children] feeling a bit distant, I’ve got two others that keeps me going. Like having a spare, if I’ve got a puncture, I’ve got a spare, so I’m alright. That’s just an example of my every day bits at the moment. Looks quite busy actually at the moment. (Chr. Session 3)

He was distancing both through the drawing and his bike metaphor. He then acknowledged how busy his daily life is. Despite his psychological difficulties he manages to keep his balance with his children. He linked back to his previous communiwell (Session 2) when exploring TMOC:

That’s a lot better, because remember I sa, sa, [stutters] oh here we go – I said to you last week someone’s got to talk for me I can’t talk about it, you’ve got to trigger

it – that’s easy then I can just come out with it ‘cos my mind’s got so much in there that a little bit at a time it’ll come out – yeah. That’s where you want to be isn’t it – so at the moment mine’s going like this – [frantic scribbling] so you can’t see the end of the tunnel, so I’m hoping that there is an end and there’s probably lots of obstacles in the way which there is at the moment, it’s like going over the assault course – there’s a 6 foot, 12 foot, whatever gets in the way you’ve just got to try and bash it down – and that’s quite tiring so I take one step at a time. (Chr. Session 3)

Again there was the emphasis on releasing a little bit at a time. He intermingled military with childhood experience. His metaphors displayed similar temporal shifts within the dramatherapy and his life. This shifting between child, soldier and veteran is his normal way of relating to the world. When he entered the military aspect his energy levels increased and were revealed in his scribbling as he sought ‘to try and bash it down’.

That’s why being number 6 [referring to frame 6 of 6PSM from the previous session] is a perfect time to talk about this ‘cos I see reality – I still feel disgusted with myself but there’s a chance I won’t have to keep buying bars of soap – there’s a chance that I won’t have to y’know – d’you know there’s a chance I won’t have to look at everything in such a grey manner, because everything’s grey when I’m down, and perhaps then I won’t have to feel I have to hide and go back under my rock like a hermit crab – so, yes, this is good whilst I’m like this, it’s brilliant. If you’d showed me that 2 weeks ago it wouldn’t have even sunk in. I know that for a fact, I would’ve just been blank. Even though I was still blank to start with today, we’ve got through something – you’ve twigged about something – it’s helped a lot. I’ve got to be in a positive to do it. (Chr. Session 3)

Chris expressed hope, he also commented on the need to be in the ‘positive’ to do it. In fact the oblique and distanced way that TMOC is used allows the story to unfurl. The imagery and links to other sessions were explicit. Chris has marked memory and recall problems, yet this did not impede his recall of the dramatherapy.

Theme 2: Creativity

Creativity pervaded much of each session, entwined in other excerpts and the appendices. The IPA theme of creativity built on the participants’ use of imagination to create a

response or solution to their experience. It is suggested that imagination serves to fill the gap between the world and how the individual experiences it (Pelaprat and Cole, 2011). Lahad and Leykin (2012) emphasise the use of the imagination in Fantastic Reality (FR). They explain the components of the real world: time, place and role as fixed, whereas in FR those concepts can be played with. They can reflect reality, be conjured up by the imagination or reflect a desire.

Imagination can remain an internalised phenomenon, whereas creativity results in a product of some kind. The foundation for creativity arises from the imagination. It is acknowledged that imagination and creativity are often interweaved. In his seminal work this is summarised in the translation from Russian of Vygotsky's unpublished papers (Smolucha, 1992).

All that is the work of the human hand, the whole world of culture, is distinguished from the natural world because it is a product of human imagination and creativity based on imagination (Vygotsky, 1992/1930 pp.52).

Creativity in this study was not the creativity of genius but the action of every day creativity, which has been termed as 'little c creativity (LCC)' (Craft, 2001). Craft acknowledges that imagination is a starting point for the creative action. Creativity is what leads to propulsion forward on life's journey.

In order to focus on the veteran's perception of dramatherapy I have restricted this section to their personal reflections of the dramatherapy process.

ALAN

Alan's creativity centred on building on positive childhood memories he was recalling during the dramatherapy sessions: *'To me it's cheating if you got to make a story up. My stories are real-life.'* (Al. Session 3)

This was reflected in his factual, descriptive accounts. These memories brought enjoyment and hope into the session. It contrasted with how he used metaphor. Using the communiwell he provided historical facts and used concrete symbols to tell his story. However he was able to enter into the process to create a distance (Figure 4.5) between his life now and his military memories. He expressed a feeling of safety and hope for the future at his ability to do this.

Alan: I want to put all them up there (moving figures on communiwell) take those three military things there and leaving a huge gap between and keep my wildlife and quietness and [name of place in countryside he likes to visit] far away from it.

[L: Okay]

Alan: Is that okay?

[L: Yes (with encouraging tone)]

Alan: That's what I would like to do so as I look at it now, in fact I would go as far as to keep those two together, bracket them and there is now a massive gap between them. I am quite pleased with myself that I have done that, yes split in two [different layers on communiwell]. (Al. Session 2).

Within Alan's use of creativity was problem-solving. He demonstrated an ability to move swiftly between symbolism and reality. His use of the military term 'bracket them' in this context denotes 'separating out' in order to have an advantage in battle. He expressed confidence and that he is pleased with himself for having achieved that. He emphasised this again at the end of the session:

I am, I am quite pleased at this moment in time as I'm sat here that I have differentiated the three things at the top the military to the two things that I love at the bottom [of the communiwell] (Al. Session 2).

JACK

Jack worked swiftly when he created his communiwell and then after telling his story commented on the process. He revealed that in previous therapy he had used a time-line to tell his story. Yet the communiwell had allowed him to see different possibilities as he viewed the perspective it offers. He referred to an 'hour-glass':

...it's a bit weird, um it's like it's weird seeing it in layers – normally you'd put it all out, when I've done it before, you put loads of stuff out and it gets you talking about stuff and it's weird to see it in layers 'cos it can be like a natural changing point that comes in like an hour glass like through the bottom then the incident and then you

know, I mean it makes sense because this bottom part of the triangle comes to a climax yet from the middle bit of the hourglass, that one can go as wide as you want and that was done to a point where it could like go really, really far, you don't know but um, I don't really know what to say to them all. (J, Session 2, 90–102)

Through creative expression he was able to play with ideas and in this he saw the possibility of a ‘*natural changing point*.’ As this turning point occurred he voiced that he did not know what to say the objects on the communiwell. The change caused him to want to rescript his previously familiar narrative. I needed to find out more about the ‘weird’ he had expressed several times during the session.

[L. Weird in a useful way or do you prefer doing it the other way?]

It's useful because if you draw it on paper as a timeline, um it doesn't have a lot to it, it looks very flat not 3 dimensional, it's all, it sort of puts it in a better time-line – I'd never thought of that hour-glass before until seeing it like this and noticing the pivot point, and yeah, it's got me thinking. (J, Session 2, 108–115)

Jack still saw it as telling a temporal story but experienced the hour-glass as a ‘pivot point’, a term used in military drills which might suggest marching on. There was a sense, through the story that he recreated, that there are possibilities of change.

CHRIS

Chris demonstrated creativity as he engaged with the dramatherapy. He spoke about his use of metaphor:

I use them all the time – so I look forward to these sessions and today I was scared stiff about it, before I came – not because of what we've done – I was worried – when I'm at home I can't think – when I'm away I can't think 'I've got to do a story' 'I've got to do a story' and I can't do it 'cos of the drama side of it – I can't be a drama queen, but I sat and did that without realising I'm doing it so I could use that 'cos that came from the inner me – it happened because it happened – it happened for a reason. I couldn't sit down and think 'write a story' and that hard stuff. I couldn't dramatise something, I couldn't make it into something - that is what I felt – there's a difference – to me. (Chr. Session 4)

He was unable to recognize his creative responses and in contrast to Alan and Jack, who both expressed enjoyment, preparing for the session was anxiety-provoking. This is his natural state when at home. He went on to compare his efforts with that of a veterans' theatre group, who had been touring internationally, re-enacting their war stories. We discussed that there will be options that we could explore, as he told his story.

I might pull it in and we'll make what I got bigger, which is good, or more visible, and that's what you want, the more visible – so to you – in the final outcome it will look like a drama thing, but it's our own experiences that make it into that – I'm not making the drama, I'm just giving my experiences, the way I feel at the time and then you put it into place make it into a – like those soldiers that did that thing on stage – now it was their own experiences that made the drama - I couldn't re-enact like they did, but, it was what they did – I could voice it, but I couldn't re-enact it – I couldn't pretend to go round with a gun – I couldn't do all that sort of stuff, I'd feel stupid. (Chr, Session 4).

Although he had not verbalised it, he has more of a story to tell and perhaps was anxious that he may have to re-enact elements of those scenes. He was changing 'I' to 'you', he had an expectation that 'I' can 'put it into place'. Things would become more visible. He was expecting that to happen 'which is good'. This reflected on his decision to report his abuse.

... And make it more comfortable – so sometimes bringing it back makes it more comfortable to deal with, manageable – that might have given me a little bit of space to breathe 'cos I've shown how I felt, about it – it may not make it right but it's helping.

[L: You can't change what happened but you can find ways to express the hurt.]

This is my way, through the dramatherapy – I just look at it as therapy, 'cos it is – it does exactly what it says on the tin – you deal with the drama, and I deal with the therapy - I'm trying to get better so yeah, it does exactly what it says on the tin – and if it helps a lot of people eventually, then it's done its job, and I'm happy with that [tic]. (Chr, Session 4).

Within several sessions Chris made reference to having enough space, he amplified this with 'space to breathe.' His idea of apportioning the drama to me and therapy to him was

another way of making things ‘*more comfortable to deal with.*’ The man beneath the muddy suit was tentatively breathing in possibilities.

Theme 3: Embodiment, Projection, Role (EPR)

EPR is a developmental concept used within dramatherapy, the use with adults is discussed in Chapter 6 (Jennings, 1992, 2004, 2012, 2016).

EPR	Developmental	Adult	Session (participants)
Embodiment (E)	Gestational to one year. Involves bodily movement and senses. Leads to the development of the body-self	Building or rebuilding sense of self. May regress or dissociate. Seeks nurturing. Learn to trust senses, and repair if not permanently disrupted through physical injury	1. 6PSM (all) 2. Communiwell (all) 3. TMOC (all) 4. Story-making (all) 5. Text reading (all) 6. Text reading (all) 7. TMOC (all) 8. Text reading, 6PSM (all)
Exploration	Sensory: touch, taste, smell, sound, visual	Titrated engagement of senses. Where impairment permanent, discovery of compensatory senses	IPA confirmed each participant explored senses during every session. There was no discovery of compensatory senses
Projection (P)	One to three years. Begins to respond to the world. Sensory play acts as bridge between E and P. Involves extending beyond physical body into world	Expression of internalised feelings. Extending into the world. Moving beyond self	1. 6PSM (all) 2. Communiwell (all) 3. TMOC (all) 4. Story-making (all) 5. Text reading (all) 6. Text reading (all) 7. TMOC (all) 8. Text reading, 6PSM (all)
Interaction	Play involving objects, imagination and the developing 'as if' phenomena	Play involving objects, imagination and the developing 'as if' phenomena. Use of metaphor	IPA confirmed each participant used imagination and metaphor in each session. They all used objects in the communiwell, story making and TMOC
Role (R)	Four to seven years. Enactment of R of other, learning about self and others, increasing sense of context. Directing self and others	Enacting roles of self and roles of others. Rehearsing roles. Deroling	4. Story-making (all) 5. Text reading (all) 6. Text reading (all) 7. TMOC (all) 8. Text reading, 6PSM (all)
Social	Creation and acting of stories, characters, improvisation, movement, costumes, props, becoming another, individual or group sharing	Creation and acting of stories, characters, improvisation, movement, costumes, props, becoming another, individual or group sharing	Story making (4) each participant tried on different characteristics and built on these for roles. In the text reading (5) they chose which roles they might absorb and which aspects they would discard, Later (6, 7, 8) they interacted and rehearsed with one another

Figure 5.6 EPR Jennings (2012 pp. 180-182) applied to IPA findings

ALAN

Alan readily identified with Odysseus in the text reading:

... well, there are bits when it gets a bit tight a bit close to you... and they do hit you. I'm a bit sad, sadness came up pretty quick. Then bits of it do get you cross and angry and I do, I did pick it up pretty quick then, not just reading it, I suppose when you're playing a part. You do get the feeling of it, don't you? (Al. Session 5)

He referred to 'feeling' the part, although we were just sitting in chairs at a desk; he was transported to Ithaca in his mind. He made the links but was also distanced enough from the event to step back from the role:

... it's in the past, but everything he's done, you've done, obviously not like him but I have been involved in situations like him but [drops voice]. The situations have gone but the story is still there. You can read that story any time, and as you know that story is thousands of years old.

And that might be a bit frightening to some people. But there are bits in it of course, as well, that he's put in of green fields and nice things. So I am trying to pick that up now, pretty quick, birds singing and colours and that, so I'm trying to find all of those good bits pretty quick. Yes am trying to pick out, I'm trying to not do the bad bits. (Al. Session 5)

Alan experienced a physiological reaction to the text reading. He recognised this and stated he was picking out the good bits. This could be interpreted as avoidance, however it was an established coping skill he referred to when speaking of focussing on something good. When he was in difficult situations he would focus on nice things. He showed an ability to discern what invokes uncomfortable feelings and memories. Instead of being overwhelmed, he showed mastery, selecting part of the text that helped him to feel relaxed and asking to read it through twice. He elected to read both parts.

[Odysseus] ... lucky beyond all imagining, but my thoughts are in a mess, my senses are befuddled, the wind whistles in my ear, the sun has warmed my brain and salt water has fouled my blood. The workings of my mind are out of kilter with the world. I'm completely lost. I have to ask you what island is this? [Said with confidence and

passion], you really don't know. [He paraphrases] No I don't know, hand on heart. [Athena]... Don't you recognise this famous place, these rocky outcrops and jutting crags. It's not huge, but it's rich in woodland and birdlife and the wells never run dry, and crops and vines thrive in its deep soil, and goats and cattle are fat with milk, and herbs season the air. (Al. Session 5)

Alan's body relaxed and he breathed in as if smelling the air in Ithaca; he exhaled slowly and smiled.

Alan displayed embodiment through his engagement with the senses. He was able to discern and reject the befuddled senses of Odysseus. Instead he consciously chose 'those good bits.' Entering the realm of fantastic reality (Lahad and Doron, 2010) he built on Athena's description of Ithaca, birds sang and he created colours. He physically inhaled the experience and the physiological changes were visible in a relaxed state, signalled by a smile. He revealed that he projected part of his own experiences into the text reading of Odysseus, he recognised that the reading caused bits 'to come up pretty quick.' Moving on to role Alan commented 'when you're playing a part. You do get the feeling of it, don't you?' He identified with Odysseus as a fellow warrior yet opted for the part of Athena to create a distance, which enabled him to achieve another perspective and regain a sense of control.

JACK

In Session 4 Jack presented a commentary on Dante's *Inferno* and was now describing feelings invoked by his exploration of the text. He recounted his difficulties at work and his feelings of being discounted by young colleagues:

... you end up talking about stuff in the military and that - yeah I did this, yeah I did that, and they look at you , they don't have to say it, they just look at you – you're not 21 anymore and that and they know you're struggling and that gets me going. That's more hopeful like, yeah I can do that and actually I'm doing the same job as you lot, and I'm sick, I'm actually sick and I'm on the same pay as you and actually, honestly, I'm better than you and I'm sick – imagine what I could do if I wasn't sick and it's 'uh uh uh' you've got no idea how switched on and how good we were – and the British Armed Force is so good. (J. Session 4, 332–338)

When he recounted this there was a change in Jack's body posture. He sat more upright, his voice became more confident and he projected it more. He relaxed. I think it gave a glimpse of how he was before the physical and psychological injuries. In terms of the embodiment part of EPR he recognised how his physical as well as psychological injuries have impacted on him. He acknowledged 'struggling.' At the same time he identified his sense of who he is. The connection he made with his story of Dante's *Inferno*, provided a vehicle for projection. He imagined himself functioning in the real world.

L. When you start talking about that and things, do you notice a change in your body and how it's feeling?

Jack: Yeah I do.

L. Is that a good change sometimes?

Jack: It is, yeah what's good is I love getting into a, not so much an argument, but to put my point across fairly and controlled, to other people. 'Cos people back down when I'm angry anyway, 'cos that's just my persona, but I love getting through to people - I love it when people realise how good you were, 'cos we forget all the time just how good we are. (J. Session 4, 339–346)

He had moved into the role element of EPR, initiated by the change in body posture. When Jack focused on this internal change he was able to recognise the difference between responding through being in touch with his military role, rather than the anger that he identified as his persona. He identified positive memories from his military service, which was so often buried beneath his traumatic recall.

In Session 4 Jack reflected on the learning that can come from folk tales and his intention to explore their meanings in modern life. He then talked about moral duty and how he cannot understand people passing by someone in need. Then he referred back to his service:

After the accident I get all these real bad feelings of guilt and never doing enough. A lot of it 'cos we didn't come home ourselves yet you see horrible things all the time yet there's no help. (J. Session 4 / 418-420).

Jack had a period of homelessness and would have experienced people passing by. When he referred to ‘not coming home ourselves’, I also think it described the changed person experienced by friends and families – often referred to as ‘not being themselves’. Indeed it was as if some part had not returned home. There was a merging of past and present, the horrible things Jack referred to, are the scenes he saw when serving and the images that still return to haunt him.

CHRIS

Chris had been carefully taking the Russian dolls apart, staring at them and putting them back together again. He described his negative body image as ‘... *dirty, unclean, worthless ... people look at me like I’m not grown up*’ (Session 3). He judges himself and feels that everyone knows about him. That is when he feels that to be in his shell is safer. Paradoxically he said he was feeling good in the session, so I asked him to do quick body scan, to see where that feeling was.

... It stays here – here the eyes, it stays with the eyes and that’s good, I suppose the eyes and the brain, it’s got to be the brain ‘cos I’m still thinking. But yeah that’s as far as it goes. I’ll go home tonight and then morning, it’s the same, I still don’t like myself, I still hate the person I am, or the person that’s inside or sorry, the person that’s outside, but at the moment I’m managing to deal with that. It’s tiring, so at the moment it’s like I’m putting on an armoured suit and getting outside. I’m thinking there’s sunshine out there, put the armoured suit on and get out there and try it. But it’s a heavy suit, taking it off and relaxing. That’s the worrying thing, when I’m back in I take it off. I’m shattered and it all starts coming in again. It’s not a dry sponge and you wipe the surfaces, wring the sponge out you put the sponge back down and you leave it and it soaks up all that water again. The water to me is all the mess – it might sound like I’m talking in riddles. (Chr. Session 3).

He identified the positives, his eyes and brain work, he is able to think. However it stopped at the eyes and the brain, when he goes home he still hates his body-self. He reverted back to the protective armour and the toll or perhaps toil of wearing it. He then introduced the metaphor of the sponge. In that description I found I was getting lost, struggling to make sense of, or interpret where he was going. He then remarked about talking in riddles. What I think I was feeling is that confusion which is with him constantly. The metaphor of solid,

strong, rigid elements of armour contrasted with the soft, flexible elements of the sponge, that mops up but then becomes weighty with the water and needs 'wringing out', before the process is repeated. EPR is fluid and a circuitous not linear process for Chris. His protective armour although a burden, is also a defense that serves a purpose and contains his turmoil. In terms of embodiment, he verbalised his tendency to dissociate as a protection from the trauma he re-experiences. The projection he used whilst devising his TMOOC drawing and the Russian dolls became a vehicle to externalize his story. The use of the metaphors provided aesthetic distancing to paradoxically go deeper into buried feelings. He put on the armour, trying out his familiar role of the soldier. He explained that role helps in his interaction with the world. Then he finds the burden of the armour too heavy to sustain and retreats. Once the armour is off and he lets down his guard, the traumatic memories flood in again.

During the text reading Chris compared the experience of Odysseus with his own:

That's right yeah, so that's probably why he had to be disguised, but she's [Athena] given him a reason why he's disguised. We haven't got that reason, why am I disguised, why am I underneath? I've come out [of the military] now, I'm with my family now, as in that's what I should be – everyone seen me for what I am as opposed to the person that's not there. (Chr. Session 5).

His feelings of being hidden were apparent; he feels Odysseus had a reason, to avoid being killed by his enemies. 'Why am I underneath?' He returned to his Russian doll theme. There was a strong sense of loss of his real self.

Chris read the *Odyssey* text fluently and using expression. He commented on the text where the sleeping Odysseus is left on the beach.

The only thing I couldn't think at first was why he stayed asleep when they picked him up and carried him onto the beach but then, we are all asleep aren't we? ... We're not there yet. (Chr. Session 5).

Chris's feelings of unreality are often of a dream-like or nightmarish quality. There was a sense arising from him that we are in it together – and there is much more to do. It also underlined his difficulty in differentiating self from others.

Superordinate theme: Coming home to self – the longest part of the journey

ALAN

Throughout the dramatherapy sessions Alan showed a determination to improve and manage his life more positively. He identified how it felt to still be away from home, in his mind. The possibility of *marching on* was voiced in his TMOC in Session 3. This contrasted with his difficult start to the session.

I never thought the long path would ever, ever, ...it's just come into my mind in the last few minutes and what's gone on in the last few weeks [dramatherapy research] I just wanna get – keep walking, to get out of it.

[L: Okay, and you see that as a positive?]

Yeah.

I know I'm laughing now, I'm walking and walking and on this stony road it's going to hurt my feet, I'll just have to put some cream on it I will just have to put a bit of cream on it.

[both laugh]

(Al. Session 3)

The session had been intense; I felt we had been on a tiring journey even though physically we remained in our chairs. The laughter marked the transition and a sense that something had shifted – sometimes it had felt like a dance, at others a route march.

Alan (laughing) I know I like walking but I'm thinking I'll be on my knees.

When I get blisters, I don't get blisters, but I think I wanted to remind me of that, to remind me of the future ... just to remind me that I've just got bad feet so what. That's it that was my delay coming here. I almost want to get walking now. (Al. Session 3)

On a deeper level, maybe Alan was referring to the fact that dramatherapy, or his struggle, would hurt him metaphorically speaking. Being on his knees linked to the spiritual issues and praying that he referred to in his previous session. Alan's shift in body posture, laughter and increase in energy suggested a positive response to the session and readiness for the challenge.

JACK

Jack was reflecting on his reading, playing Odysseus. Odysseus literally fights for his place when he gets back home. As a veteran Jack is fighting metaphorically and in the past physically for his place in civilian society. However through the dramatherapy he was reframing some of his experience to propel him forward.

I've never had a home to come back to, I still feel like the traveller, and don't know where I am going and I had it read to me that he's got to suffer to get enough strength from it, and that's what I think a lot about myself, I've got to suffer to get the skills I need to sort it out.

... I took a lot from it, I enjoyed it. I was talking about it and that and I do find it intriguing. (J. Session 5, 816–819, 829–831)

Jack identified the possibility of gaining strength and skills from his suffering. He was no longer lost in the unfairness of his situation. He sat alert and expressed excitement and enjoyment of the dramatherapy process. He spoke of his intention to get more audio books to learn more about Greek heroes. In psychological terms he was demonstrating PTG in a concrete way.

CHRIS

Chris was reading the part of Odysseus. *'A nightmare 20 years in the wilds of the world. Then I open my eyes and I'm home. I wake from sleep and I'm home'* (Homer's *Odyssey*, p.205).

That's the bit I was on about earlier, wasn't it. But he's still the old man, so he's not actually him, he's not there yet is he? He's on his way, but when you're listening to it there, it sounds a short distance from now on, to what he's got to do – that's the longest bit for me. This bit's going to be the longest, returning to his self again. (Chr. Session 5).

This resonated with Chris. Like Odysseus he still had not returned to himself. A comment often used to describe someone who is mentally unwell is 'they are not themselves.' He commented [Odysseus] is on his way. From his own experience he was able to recognise that the seemingly short distance is the longest. Similar to Jack, his time-line is not linear or congruent with the every day understanding of time.

Theme 1: Preparation (for the journey)

ALAN

Reflecting on completion of Session 3 Alan suggested that better preparation for the session would have assisted in the journey.

That was hard today that was one of the hardest ones I have ever had to go through.

[L. 'Right, so overall as a therapeutic tool would you think it is useful or not?]

Yes. Yes, I do. Because straight away when you asked that question you got me to say what I was going to see, I didn't have a choice it was there. I never knew, I came in here thinking I was going to put some objects here on my cake stand [communiwell] and just talk. So it threw me out a bit. Probably most people like me would want to know that... Like when we used to do on the Warrior Programme – put yourself in the room put yourself when something traumatic happens, it doesn't work like that because if you are military or whatever you can avoid it- but with this it's something that is there. (Al. Session 3)

Alan had thought he would be using the same method as in the previous session. Although I had explained at the end of the last session what we would be doing, I should have written it down, as recall is a frequent problem for trauma sufferers. He took the cue for the communiwell as it was on a table within the room. He provided important information about how it is possible to avoid going into too much depth. Most people within the military have been trained in avoidance techniques. He commented more preparation and warning of what to expect might be useful. It could be argued that it would not have been so beneficial if he had been able to censor what came into the session. However, the risk had been that he might have refused to engage further if he had become overwhelmed.

JACK

Jack discussed his new experience of listening to an audio book of *Homer's Odyssey*. He showed his continued commitment to the dramatherapy process. He prepared for the next session but went further than that with his own exploration.

... it wasn't so much hard work it was just so emotionally draining – listening to that book over the weekend really did me a lot of good, I enjoyed it 'cos I shut off the world and it was a beautiful day and I was walking up and down the flat and my missus was laughing at me 'cos I had big headphones on – I was really into it, I was really intrigued by it and there were just loads of little bits I took from it.

(J. Session 5, 154–160)

He returned to the fact that whilst concentrating on listening to and researching stories he was able to shut out intrusive negative thoughts and enjoyed the process. His shutting off the world, could be regarded as avoidance. Alternatively for Jack who experiences being bombarded with intrusive imagery, he saw it as a positive experience. His wife had also become interested and involved in his quest and they had shared laughter. His wife's involvement was a contrast to the times he shut her out of his troubled life.

CHRIS

Chris referred to Odysseus agreeing to be disguised. His interpretation echoed his earlier metaphor, '*the man inside the man*'.

Yes, that's what I'm saying, at the moment he has [tic] 'cos he's inside himself – he wants to show himself, he wants to be himself again, but you've got to do it gradually. Mm he also agrees to being like that until he can get through it, get to where he's got to go. But that's the comfort side – you know there's the murky side and the comfort side, and that's the two things I thought of. Being indoors to be safe and being indoors um being locked up, so being trapped. So he's trapped but he's also safe. (Chr. Session 5.).

This reflected Chris's ambivalence about the cost of keeping safe. He emphasised that the need to change has to be gradual. He recognised his own need to move slowly towards recovery.

Theme 2: Reconnaissance

ALAN

As Alan commenced his TMOC I enquired whether Alan's military training could help him to plan his journey, he responded

'The important thing is I pick the route, where I want to go, no one tells me, I decide whether I want to go [chuckles]'.

He described how he was shaking at the start of the session; *'but now [inhales deeply] can I just look at you and say I feel in control. I can pick the path'* (Al. Session 3).

Alan frequently checked out that he had got it right. I do not believe that was just his concern in the moment, it was an attitude from his military self, where getting it right, being the best, was at times critical for survival and at less urgent times had been instilled to ensure he could deliver whatever he was ordered to do. The shaking he referred to at the commencement of the session was related to an intense memory of an incident, and the muscle group affected replicated a muscle memory from that traumatic recall. His somatic experiencing of the memory manifested through the severe shaking (Lahad, Farhi, Leykin, Kaplansky, 2010; P.A. Levine, 1997). His release of the energy resulted in his changed posture and interaction displayed by his deep inhalation, deliberate eye contact and assertion that *'I feel in control. I can pick the path.'* The change suggested a turning point. He was physiologically as well as verbally displaying readiness for moving forward. It also was a rebuttal to the fact that he had felt unprepared at the commencement of the session.

JACK

During his TMOC Jack illustrated his ambivalence about who he is since his accident, he described being at war with himself. He viewed himself as having 2 parts,

It does feel like that - I've said before in metaphors about Batman – I always wanted to be the Batman, to go forth – it wants to encourage me to help others and it wants to keep reminding me where I belong and what your true colours are. (J. Session 3, 376–379)

It comes from feeling weak, that you want just to be left alone, and the isolation, it's like the flight thing, you feel like shutting yourself in, you feel unbelievably weak, but it goes from one spectrum to the complete other – one minute it's bend your knees, bend your knees, your body wont work, you just can't take it any longer hearing someone making a noise or fighting, then all of a sudden, it flips over to anger. (J. Session 3, 547–551)

I go from complete terror and fear to weak, I find the flight response, it only goes so far then it hits in, it hits in, and goes 'No – that way'. Then it's fight, fight. (J. Session 3, 554-556).

Jack described succinctly, how he experiences PTSD. The use of his TMOC drawing as he related his journey provided a focus. His story was peppered with references to common symptoms of PTSD (American Psychiatric Association, 2000). He identified the dilemmas that are obstacles to his progress on his journey towards reintegration. The identification of the obstacles on his pathway gave him a sense of purpose. He summed up what he wants to achieve.

I do, I want to win, in a bizarre way, it's not really a competition, but I want to learn how to beat all this other stuff and once I've cracked it and worked out how to do it I want to help, with housing and everything else. I want to be able to use that information properly. (J. Session 3, 617–620).

In Session 5 Jack continued using his reconnaissance skills and there was a temporal shift as Jack employed his military skills to plot the course of Odysseus's journey in our times.

'... so I thought I'd have a look at it, I even got the maps and they plotted modern day where they think his journey took him in Homer's Odyssey, which was quite good' (J. Session 5, 52–55).

He returned to the mapping further on and explained to me Hades is where the Straits of Gibraltar are. He was animated as he discussed his discoveries. He enjoyed using a familiar process [map-reading] to problem-solve. He was moving beyond the text to look deeper into the story, mirroring the research process.

CHRIS

Chris identified with Odysseus waking up and not recognising Ithaca.

Because it's not him, there's bits of him coming out there, bits of the real him coming out, but it's not quite him yet. So glimpses of happiness – he knows he's been there before, but because of the trauma he's been in, he's not sure where he is, I don't know if he thinks that's the battlefield or the safe place when he wakes up – is he just in the place again – until he recognises the shape of the stones [tic] like everything here, when we're having a bad time it's grey, it all looks the same, but when it starts lifting,

or when I've had a bad night and I wake up and when I see the dust and that come down and the ceiling's collapsing it looks real and I wake up the next day or the day after 'did this really happen?' (Chr. Session 5).

Reconnaissance includes having some recognition of what happens when reality shifts and how to find the way back from that. Chris's plea for a gradual process made sense when he voiced his experiences, prompted by the reading of the text. He identified with Odysseus when waking up, the sense of familiarity of the place, yet unable to discern whether he was in the battlefield or the safe place. The periods of dissociation described by Chris, demonstrated that for him at times reconnaissance was not an option. After such an episode he needed time to re-orientate to his surroundings.

Theme 3: Marching on

ALAN

One of the fears Alan expressed is the possibility of losing the ability to walk long distances. Now he said 'so what.' The paralysing fear had abated. He came back to reality by referring to his delayed arrival - he had been trying on new walking boots. He wanted to move forward, feeling equipped for the journey.

He reflected on the use of TMOC. He thought it was very good that he found a way out of a 'most difficult memory' involving a fatality. He did not feel tired afterwards but enthusiastic. He made a link that images take him straight to physical sensations:

There is a sense to what this is all about. I sense straight away vision and sight and then feeling, then hearing, smell is the last one. It's feeling, it's nice, it really is. There is chance and choice there. There is a resolution. (Al. Session 3)

He laughed at his use of 'therapy speak'.

In his reflection he contradicted his earlier statement that he '*did not have choice, it was there.*' The intrusive memories of the fatal incident 'were there straight away' as I was giving him an example of how TMOC could be used. He identified that through TMOC he had been able to find his way out of the memory. This way out had engaged all his senses as he employed his imagination in the process. The model had paradoxically provided him with distance that he reflected had resulted in resolution.

JACK

Jack was still exploring his way to move forward. He reflected on the text-reading of Odysseus returning to Ithaca (Appendix 1) and how it resonated for him.

I find it weird that you have to be punished again by going through the back door. I've done that a lot, but it's the same with coming out of the Force as well, it's like – you know what you've done, it's all you'll ever know, and you come out and it's like 'oh yeah, so you used to be a soldier' like there's no kind of language to recognise what you have done. (J. Session 5, 806–809)

Jack was moving forward but still pondered on his themes from prior sessions of injustice and the lack of recognition he received for what he had endured. When he said *there is no kind of language* it is possible that the play text was helping him find that language and that was borne out as the session progressed.

CHRIS

It's that strength – trying to batter down those walls – it's very difficult at the moment cos there's a minefield all over it so everywhere I step I'm frightened I'm gonna stand on something, so I try not to step 'cos sometimes I step and it do blow, so then you think 'Oh God I think I've got the right path and then all of a sudden, someone's put a mine there' – so I go back again, so that's when I go back in my shell, I go back in the house. I think I get brave, I get brave and I go out again and have another go at it, so I think of another path, so yeah I do use maps but in a different way so I think of another path – it's a puzzle. (Chr. Session 3)

Although he was fearful, Chris was not giving up, he asserted if he stepped on a mine, he retreated to gather his strength and try again. He finds it a puzzle, yet to be solved. In storytelling mode he was able to express this as a brave act. His normal self-deprecation subsided. This echoed his determination expressed in the previous session.

So that what keeps me going – the chance of hope, people keep saying there's hope, so I take that, I take bits of what they say and that keeps me going, that gives me the strength to push down and that's the inner strength, if I hold that I've got a chance. (Chr. Session 2).

What kept him going at surface level is 'taking bits' of what others say, suggesting his need for an external locus of control. Using this hope he continued putting one foot in front

of the other, marching on. He has also battled suicidal impulses and that glimmer of hope has pulled him through those dark times. Chris referred to the ‘strength to push down’ using terminology he is familiar with in his weightlifting training, where the ‘push downs’ strengthen the biceps and triceps. Through his reflection Chris recognised his ‘*inner strength*.’ He has faith that there is light at the end of his labyrinth of tunnels.

Group sessions

Alan, Jack and Chris stepped up to dramatherapy group-work for the last 3 sessions. The IPA process was carried out in the same way, looking at individual responses and then considering group influences related to the research questions. The selection of themes remained consistent with the themes highlighted in the individual dramatherapy sessions.

Mindmaps were colour-coded as before and shapes allocated for each participant. Group themes were added in green. If instigated by a particular participant, the theme would be outlined with their allocated shape. An example is provided in Appendix 8.

Superordinate theme – ‘The King of Oblivion’

Alan, Jack and Chris returned to this theme as they took it in turns to read from *Homer’s Odyssey* text (Appendix 1).

During the text-reading from *Homer’s Odyssey* they all shared that the experience of returning home (to civilian life) had been like ‘sneaking in the back door’ (Al. J, Chr. Session 6).

Theme 1: His[s]tory

ALAN

In Session 7 each participant brought a story or poem related to *Homer’s Odyssey* to share with the group. Alan told his own personal story (Appendix 12). After praise Jack commented to Alan that he had told him he was going to write something about the play. Alan replied

No. I couldn’t, because every time I thought about it, things came up, and Linda, you know that some of the things I’ve had to deal with you with. (Al. Session 7)

Alan elected to tell his own story. He displayed an ability to problem-solve when *Homer's Odyssey* text threatened to overwhelm him. His imagination, stimulated by the text, was in danger of being less contained than his own factual story. After the feedback from the group, Alan sat back and laughed.

Well, I must say that it feels good and that's that. (Al. Session 7).

The sense of anxiety that had been present over sharing his 'homework' had dissipated. He expressed satisfaction and a sense of achievement at what he had created.

JACK

In the final session Jack identified that dramatherapy had allowed him to work through his own story.

Mine was about the fire and instead of constantly being dragged back by it I was able to go forward to get rid of it. It was like a plan within my head I was able to say this is me, telling my story. I was not caught up in somebody else's. (J. Session 8, 66–69)

Similarly to Alan, Jack had been able to step back from being overwhelmed. The stepping back was not avoidance, rather it was a turning point. He had used problem-solving and created 'a plan within my head' enabling him to move forward both physically through enactment and metaphorically. He had been able to make a shift and own his story. He was not burdened by someone else's tale.

CHRIS

Although Chris found the dramatherapy difficult at times, in the final session when reflecting on his story he had explored using TMOC in the previous session, he demonstrated his determination to follow his pathway to recovery. '*Now I'm in control. I'm going to do it for me*' (Chr. Session 8).

The reflecting back to that session appeared to propel him forward. This was a turning point for Chris. He previously tried to make things right by helping others and discounting

his own needs. He spoke clearly and loudly with no stuttering or tics. He had found his voice.

Theme 2: Cultural

ALAN

In Session 6 Alan invited us to consider the context of *Homer's Odyssey*. His horizon was expanding as knowledge of other cultures, gained from his military experience, emerged.

When I look at that book. I know this is a modern version but I wonder how many countries that it has been translated into. Would fundamentalists have the same stories that we do?...Yeah I'm just saying because we can relate to bits from it and I just wondered whether anybody else in the world could or their Armed Forces do.

(Al. Session 6)

Through the play text there was a sifting and sense-making that moved beyond his immediate life experience.

JACK

Jack had already commented on how much can be learnt from other cultures.

The interesting thing about that is I always try and learn about their stories. Who do they class as a hero and why? (J. Session 6, 467)

The exploration of other cultures had been important. The discussion that followed demonstrated engagement with the text and looking beyond the written word in an attempt to make sense of their own positions in relation to others.

CHRIS

Chris expressed the cultural values he felt they shared as a group. '*We are all of the same cloth ... we just do it differently*' (Chr. Session 8). He moved from feeling an outsider to sharing common ground.

Theme 3: Spiritual

Spiritual discussion permeated the sessions. Sometimes it was tentative as they sounded each other out. The final session of story making, reflection and ending ritual crystallised this. The group asked to complete the 6PSM together. Shackleton, the famous explorer, was their heroic figure. When we got to the square on the 6PSM drawing where I asked them what or who might help it was a catalyst for their discussion.

CHRIS, JACK, ALAN

Chris: Yeah Jesus, but would that be enough?

Linda: You can come up with several things if you want.

Chris: Yeah because I don't think prayers are enough are they?

Jack: Sometimes that's all we've got left.

Chris: I still use them.

Alan: Yes we pray.

Jack: Yeah.

Alan: We have faith and hope. We don't want charity.

Chris: We have faith and hope. Can you write a thought?

(Session 8)

CHRIS

Chris was drawing as he talked so he did not need to make eye contact. He was used to having prayers unanswered stretching back to childhood, yet he still expressed hope. He was not afraid to say he still prays. Alan and Jack listened supportively, with respect and then added their perspectives. At the end of the exchange Chris sought clarification on the process as he wished to put words on the 6PSM.

JACK

Jack had voiced before that he is not religious, yet expressed a spiritual knowledge and understanding, having introduced his view of Valhalla. He reflected that perhaps prayer is all that is left. He underlined this

Another saying in the military – there's no atheist when in trouble. I remember when I joined up a Padre giving me a bible and I said no thanks mate, you're all right and he said there's no atheist in battle. (J. Session 8, 657–660)

Chris and Alan agreed with him.

ALAN

Alan had spoken about his faith before but in this exchange he spoke firmly and added that they have hope. However he rejected the notion of needing charity. This alluded to the burgeoning number of charitable initiatives, some of which are welcomed but some of which may inadvertently patronise those who have given much and still want to be able to give more. His confidence in his ability to help himself and other veterans had grown.

Superordinate theme: 'If there's some glimmer of light, if you can see the man under this muddy suit ...'

Theme 1: Storymaking

ALAN

Sometimes it seemed that the man under the muddy suit could not find himself. As part of the storymaking Alan was in role, interviewing the returning Odysseus [played by Jack]. He asked a spontaneous question: *'are you the same old man? Do people see you the same? Do you feel the same?'* (Al. Session 6).

In this question Alan summed up a common plight of the warrior. Who is s/he? What lies within? Although questioning Odysseus, Alan was projecting on to the character, his own predicament, that loss of self.

JACK

Jack was stimulated by exploring the text and enjoyed playing with concepts. He gave us a glimpse of the man he can be when not weighted down with trauma. He carried on with this exploration between sessions.

A lot of these stories were always broken down anyway. For instance, Cyclops and we can talk about Hades or perhaps Godzilla, it's a 2000-year story we haven't

even touched on what's happened before. Odysseus was a right smart arse he made a horse, and hid all of them in it.

All laugh. (J. Session 7, 104–111)

Jack brought another perspective to the story and talked in an enthused manner. Using humour engaged Alan and Chris. Jack looked back in order to move forward.

CHRIS

During the final session when engaging in 6PSM, when asked to think of something or someone that may help he replied:

I find this a bit difficult, I can't think of anything. I can see it and now ideas are coming in. (Chr. Session 8).

The second part of his statement appeared to conflict with the first. Conversely when he looked at his drawing he moved from cognitive to visual 'and now the ideas are coming in.' He moved swiftly from his habituated 'blanking' to expressing his ideas. He was able to express to the others that for him, this was not such a spontaneous process as they experience. Rather than jumping in with suggestions to solve his dilemma, given time and a literal shift in perspective from thought to image, his creativity buried within emerged.

Theme 2: Creativity

During the sessions much of the subject matter was grim. Dramatherapy provided the opportunity to witness those stories. It also allowed for a creative response. Rather than become stuck in a memory, playing might produce a reframing or transformation.

ALAN

During his TMOC walk- through with me Alan replicated an abstract battle scene. This evoked strong emotion and whilst leaving me *holding the ground* he retreated to his safe space. Taking a deep breath he returned to the scene and instructed me to *stand down*, stating that *we have been victorious and the battle is won*. There was a sense that it had been an internal battle as well as a re-creation of a memory. There was a change in him physically as well as mentally at this turning point. He walked in a purposeful upright

manner to his destination but then said he wanted to go back to the start and walk through the nice [transformed] parts.

Right. I have a vision here of the nice rocks and nice sea, that's good. The insecurity down there (gesturing down the model) has gone. (Al. Session 7).

His eyes watered; this time he said it was with happiness. He rehearsed the scene again, building on the positive images, sights, sounds and smells. It was as if he was emerging from his muddy suit. He was enthused addressing Jack and Chris.

You've got to have a go of this. It's not difficult. It's just what comes into your mind. ... Honestly, it's really good. I was just travelling and thinking what the bloody hell is happening here. And it's changed. (Al. Session 7).

Alan emerged from his creative playing expressing a hope, which he wanted the others to experience for themselves.

JACK

Jack had been immersed in the creative process since the beginning of the research. Even when he was experiencing conflict and anger outside the sessions he had discovered that the creation and exploration of stories, reflection and reframing gave him respite and allowed the negative feelings to dissipate. Despite this at times he found the process hard. This was reflected as he introduced his poem (Appendix 12). ‘... *I'm really enjoying doing this, although it's hard. 'The agony inside my head'.*’ (J. Session 7, 348–349) He summed this up in the final dramatherapy session. ‘*To be honest, this is the best therapy I've had. I've really enjoyed this.*’ (J. Session 8, 518–519)

Jack's drive to embrace his creative process reflected the way he responds to challenge; instilled in survival instincts in childhood and reinforced during his military career.

CHRIS

Chris continued to use metaphor as he weaved his way through the sessions, accompanied by the Russian doll he used to illustrate his ‘man, inside a man, inside a boy’ theme. At times spontaneously dialoguing with it, he took on a nurturing role with the doll. In TMOC

when he decided to repeat (rehearse) his walk-through he picked up the doll: *'I can bring him with me which is what I want isn't it [places the doll on the floor at the end of his journey line]. Go on boy.'* (Chr. Session 7).

Chris demonstrated creative ways using dramatherapy to work through his personal story. The Russian doll he opted to use provided a symbol of his internalised struggle. It had also taken on a living value for him as he looked after the 'boy' as he never experienced being looked after when a boy himself. He became tearful as he addressed the doll. Unlike Alan and Jack, though, at times Chris struggled with the creative process. His vivid imagination could overwhelm him. In the group setting he returned to the theme he identified in Session 4, that of being 'pulled in'. When text-reading the part of Telemachus in *Homer's Odyssey* he asked if he could just listen instead.

I got pulled into it too much. Odysseus I got pulled into, but I was more comfortable with it for some reason. (Chr. Session 6).

He reflected on this and decided if he gets too immersed in a part he loses himself within it. He was able to opt out of reading and listened instead. He normally finds it hard to ask for what he needs, so this marked a change. When he did not feel pressured, Chris was able to enter into the process. He then found the experience of dramatherapy enjoyable.

I didn't think dramatherapy would do anything for me but I have thoroughly enjoyed it because it is not what I thought it would be. (Chr. Session 8)

Chris experienced the creative process as a tension from which he emerged with a renewed strength.

Theme 3: Embodiment, Projection Role (EPR)

Through exploration of roles and remembering their military roles, when acting in sessions again there was a glimpse of 'the man under this muddy suit'.

ALAN

Alan commented on the warm-up phase as I directed them in moving slowly around the room, paying attention to their breathing and how their bodies felt.

Alan: If this was a long journey, like that, I could do this for days

L. Right, so you've got your pace?

Alan: Yeh, I'm into it. I've got my pace, is dead slow, I don't usually do that, it's easy, and the journey can last as long as it takes now. (Al. Session 7).

Alan was preparing for the session but alluded to the longer journey. He would have been used to pacing himself when he was in the military, for marches that may last days. In his anxiety-driven, post-trauma state, he had forgotten the sense of control within that could be found in slow deliberate movement. As he embodied this movement he prepared for the possibility of other roles.

JACK

I invited the participants to shift the way they were sitting to see what happened to their perceptions of themselves. Jack made that shift and then stood.

... if we remember how we stood up straight and proud, that immediately alters how we feel about ourselves. (J. Session 6, 138–140)

In the next session Jack reflected on how he was feeling in his body. He had experienced a negative reaction in the previous session to Odysseus being transformed into an old man by Athena. Now as he moved through his TMOC he stood tall and projected his voice loud and clear, inhaling deeply.

Now I feel like I'm 35 with the common sense and wisdom of an older man and I've still got my strength – I'm still strong, fit and fast and this is not the end of a dream ... (J. Session 7, 979–981)

He had embodied the positive traits he saw in the older Odysseus and took this forward with him as he cleared obstacles out of his way. Sometimes the physical constraints caused by his disabilities made Jack feel aged. He experienced a turning point, equating ageing with wisdom.

CHRIS

For Chris embodiment could be difficult. He has a tendency to dissociate and there was a risk that he would feel overpowered by external roles he did not want – something that

happens to him in daily life. He was able to recognise this in the dramatherapy sessions and began to make choices about characteristics he wanted to try on and those he wished to reject. Alan said he envied Chris's ability to take on a role so quickly. Chris did not see it as a positive attribute in relation to text-reading the role of Telemachus:

When I play a role I need to think of it as wearing a mask rather than it taking over.

[L You can embody a part, if there are aspects of the character you find helpful.]

I got too comfortable with it, too comfortable playing a part I didn't want. (Chr. Session 6).

Chris was able to identify his difficulty and the idea of distancing, through '*thinking of it as wearing a mask*'. When I enquired whether we could help in any way, he replied 'this is helping' referring to his ability to express what he needed and to be supported.

In the final session each participant had randomly drawn an extract of text from *Homer's Odyssey* to read out. I invited Chris to stand to read his:

Chris. "When your back is straight and your bones, the straightness of your spine and your limbs, subtlety doesn't come into it".

That's almost like getting stronger and then going all soft again. I'll read that again 'the straightness of your spine, the suppleness of your limbs, I give it back to you' and that's how I feel, I want to give that out

[L. Right...]

I'll rip mine off and give it to them because I don't need it. (Chr. Session 8)

Although Chris adjusted his body as if experiencing those things, he then wanted to give them away. He has difficulty accepting anything for himself. He was encouraged by Alan and Jack to stay with it and read the text again, rehearsing those movements and accepting them into himself. They took on a supportive, coaching role, reminding him of breathing exercises. His mood became lighter, his posture more relaxed and he laughed. They were in familiar territory, supporting each other as they would when facing a task in the military.

Rehearsal Embodiment Action Living (REAL)

The text readings and TMOC responses described in EPR were felt by the participants to be a springboard. They were reprising military rehearsal skills in addition to trying out new roles. They embodied characteristics they wanted to retain and de-roles and discarded others. They put into practice through action, both in and external to the dramatherapy sessions those roles. This produced an alternative framework for living. They coined the acronym REAL.

Superordinate theme: Coming home to self – the longest part of the journey

In the individual sessions each had expressed what coming home means to them. In the group sessions there was a sense of sharing in the journey.

Theme 1: Preparation

ALAN

Before creating his TMOC, Alan shared the story he had brought to the group. In it, he made comparisons between Odysseus and his own homecoming.

Yeah I can remember that coming back to the school and my son being scared and I thought bloody hell what have I come back to? Never mind, never mind Still. It breaks your heart. (Al. Session 7)

Alan became emotional. The teachers had failed to recognise him and allow him to collect his son. The others offered support and encouragement, identifying similar experiences. He gave himself comforting self-talk and yet acknowledged the brokenness. He was in a safe place to express that vulnerability to others who understood. In telling his story he seemed to find strength as he made preparation for his journey.

JACK

Jack prepared for each session. He showed a hunger to embrace the stories as he forged a pathway. He echoed to the group what he had experienced when preparing for his individual sessions. He explained his change in self-perception to us:

That's what I feel. I need to do it for myself. I can give anyone great advice but I haven't got confidence to know whether I'm right I'm constantly seeking approval

but now I think, you know what, it doesn't matter. Before I constantly thought I'm not strong anymore, I'm not tough anymore. (J. Session 8, 90–94)

He was leaving behind his poor self-esteem and negative comparisons that have arisen since he was injured. He rediscovered his tenacity. There was a change in how he plans to deal with conflict. He quoted:

'Be still Odysseus. Have courage' me in a nutshell. (J. Session 8, 451)

... I want to be able to be able to be strong enough to walk away from it. (J. Session 8, 451, 455–456).

What he had seen from childhood as being a sign of weakness, to walk away from potential violence, he now reframed as strength. This was an important turning point as Jack had been very conscious that his violent impulses could lead to imprisonment.

CHRIS

Chris had written a poem about Odysseus (Appendix 12):

I see him as the weary traveller.

Still lost in his world.

(Chr. Session.7)

His poem then went forward to the modern-day warrior. Chris is also wearied by his experience and found the dramatherapy a challenge, but was determined to continue. He surveyed the scene, stood still and took a deep breath.

The journey I'm taking will start from there [pointing behind him, gestures forward] the obstacles I've been through so far it doesn't matter if I walk around them or not it's just, it's a big map [weaving himself through the start of the sculpt]. (Chr. Session 7)

He kept checking things out, trying to make sense of what he was doing. The dialogue with us as his audience also meant that he was not totally immersed in the model or journeying alone.

Theme 2: Reconnaissance

ALAN

Alan worked quickly to build a model for his walk-through of TMOC. He entered into the space, asking that I accompany him. Jack also joined us. Chris watched from the distance. Alan stepped into his military role and the space was transformed. He took the lead, giving instructions, making it safe.

Just follow me round here. Still looking down at this, we are checking things. We have been victorious. Now I want you to stay exactly where you are. Linda. Jack, you can go out of this thing now [gesturing to a chair outside of the model]. I'm now going to move down here. I can see very, very vivid rocks and cliffs. I can hear the gannets and curlews. I can hear everything around me. I have left one victorious battle. We now come down now going forward and I'm not going back, going forward. I do not wish to go backwards. (Al. Session 7).

Through checking out things Alan had rewritten his journey. He had also rekindled some of his military skills as he planned the route and gave precise orders. There was a sense of triumph but also a determination not to go back. He demonstrates this resolve in his quest to adapt to civilian life. He replaced the vivid traumatic imagery of battle with those things he loves.

JACK

Jack played Odysseus being interviewed by the press about his return home. He then talked about what he discovered as he looked deeper into the journey.

Yeah it was good. It went deep. I tried to answer it as Odysseus but it caught me out, I found myself matching my situations with his. I had never really thought about what it was like from my wife at home waiting for me. So instead of worrying about what's happening at home it should be about concentrating about getting home. (J. Session 6, 439–441)

His exploration changed focus from the immediate, where he was trapped by the feeling that it was an impossible situation, to thinking about the means of getting home. Although he was now at home, in a similar way to Odysseus he had not properly returned. Through

the distancing of playing a role, Jack focused on a different horizon of how his absence felt for his wife.

CHRIS

Chris continued to address the audience [Alan and Jack] as he recces his TMOC.

I can see where I want to be [gesturing forward] but [addresses Alan and Jack] if you excuse me [he wanders back through the sculpt]. I keep going over it making it smaller so I keep going back through, once I've been through the first lot it's not an obstacle any more so I go through it just to remind me. (Chr. Session 7)

He checked out that his transformation of the obstacles could be trusted. He also needed to check out whether he could trust the dramatherapy. He was tentatively feeling his way through.

He looked at where he was standing, then looked back and made a resigned gesture; he looked at where he was standing and then towards his destination.

And the journey again, we'll get to there [gesturing to the end of the journey] but I can't get to there at the moment that's where I am. (Chr. Session 7)

Chris was exploring the possibilities and expressing hope. He had managed to stay grounded. He had not been ticcing or dissociated whilst moving through his metaphorical journey

Theme 3: Marching on

ALAN

Alan reflected on the TMOC. He was not claiming his journey was easy but he recognised the scene had transformed. He brought this up again in the final session, where he spontaneously created his own path to walk through in the field. He used TMOC, following an external event that he had found difficult. He compared TMOC with the time-line therapy he was encouraged to use in other therapy

No I couldn't do it [time-line] I had to walk through it [TMOC]. I find that interesting and I think that is very useful. That helped me out the other day that did.
(Al. Session 8)

Veterans are used to being very physical in their military career. Becoming kinaesthetically engaged can lead to a metaphorical as well as physical transition.

Alan also made the point that he found what he learnt in the dramatherapy sessions was easier to recall.

Because me and Jack talked about this and we do get something from this and we actually remember what we get from it ... (Al. Session 8)

The senses were engaged in a way to form positive memories and recall rather than the intrusive recall that often shuts out the tasks of daily life.

JACK

Jack walked through his TMOC. He visibly altered his stance as he progressed. He was upright, confident and spoke with conviction as he reached his destination. He looked back at the model he had just walked through as he stood at his destination: '*... but what I thought it's more of an epiphany for me.*' (J. Session 7, 976). He gestured to the area that represented the negative military experiences.

No – no that's great, they're gone now, it's where I'm gonna go now and it's open - it's blank, it's like Highway 9 – I don't know what's coming. But unlike being here, where I knew nothing, as my military told me, I was useless, these voices are so far behind now that I can go past all this, I remember it – bad, bad, bad, bad, bad, bad, bad – but now I'm here – there, that's where I'm going (pointing forward) that's my journey. (J. Session 7, 989–995)

He was standing upright and firm 'eyes front'. He had been transformed from the start of his journey through TMOC. He addressed us and emphasised the 'bad' loudly, with feeling. He was excited not intimidated by the prospect of a 'blank canvas'. A sense of a turning point was palpable.

CHRIS

Chris stated that sometimes it is better being in the fire.

Chris: *Because sometimes you feel safer in amongst the dangers*

L *Yeah. That you're familiar with?*

Chris: [makes a sigh of relief] *Yeah. That's why I keep coming back because I'm trying to push forward [makes a gesture of pushing forward]*

L. *Right [mirrors the pushing forward movement]. Every time you push forward make this gesture if you can.*

[Chris puts more movement into the pushing forward]

L. *See how that feels to push [both repeat the movements as they move forward]*

L. *See that you've got the strength to do this.*

Chris: *[breathes out heavily] Yeah.*

(Chr. Session 7)

Chris put effort into the movement. His energy level increased as he transitioned and then lead the movement. The regulation of his breathing steadied his body. He agreed with the suggestion that he played 'what if?' just to see what it might feel like if he stood at his destination point. The others supported him to rehearse the action.

He moved into an upright confident stance, appearing to increase in stature. He remarked that he felt lighter and was 'no longer talking gibberish'.

Yeah it felt I'm at the place where I should be, where we all should be. This is where we should start. This should be our starting point, and this is where I want to be at the starting point. (Chr. Session 7)

He voiced the possibility of a new beginning. There had been a turning point, a transformation. Chris held on to this in the final session.

Now I'm in control I'm going to do it for me ... That's where it's at isn't it – you can't have it all done for you. (Chr. Session 8)

He moved from passivity to being proactive as he began to take charge of his life. He realised he has a long journey ahead, but one he can shape.

The Group

The transcripts revealed support, challenge and encouragement for one another. The cohesiveness as the 3 veterans worked together went beyond that normally witnessed in a recently established therapy group. The dramatherapy evoked the spirit of teamwork from their military past. .

Session 6

They had been discussing the storytelling in the session and around campfires.

Alan to Jack: *I was going to say you're a good storyteller mate. No but the art of storytelling's gone hasn't it? Every one of us could tell a story several stories in fact and that's what it's all about isn't it?*

[All agree]

Jack: *Yes and when we meet with other veterans it all starts coming out 'yeah I served there, no way, so did I'.*

Alan: *I think sometimes it might be better to tell a story when you're in a group and a bad thing if you're by yourself.*

Chris: *Yeah you could get lost in it if you're by yourself. You can get overwhelmed.*

(Session 6)

Alan thinks of storytelling as a dying art yet acknowledged the stories that lie within. Jack took up the theme and illustrated the typical tale-sharing that occurs between veterans as they seek common ground. Alan and Chris made the point that stories are better shared: kept to oneself they may be bad. Often there has been a need to keep stories buried, sometimes because of regulations (having signed up to the Official Secrets Act), sometimes because their his[s]tories were too difficult to share and perhaps sometimes because no one was listening. Here they had found a place to share amongst an audience who would not be shocked. The audience could help keep a foot in reality and not get lost in the retelling.

Session 7

The way the group worked together was most apparent as each one embarked on their journey using TMOC. There was a respectful listening, watching and then if the traveller appeared stuck, spontaneous encouragement and possible alternative actions, tentatively

offered. An example of this was when Chris was saying he knew where he wanted to be but was not sure how to get there. Alan took a lead:

Alan: *I think you've got to move that chair mate – make it a straight forward.*

Chris: *Straight?*

Alan: *Yeah, so there's a quicker run to it.*

Chris: *[removes chair] Yeah [he becomes more animated, walking down to start of journey]. You see this is what I want, what you just said there to be able to walk straight down and get to the end [he does so, portraying a military posture, upright, eyes front]*

L: *Just notice how that feels when you're doing that.*

Chris: *It feels a lot lighter and I can talk [makes an open gesture and smiles at others]*

(Session 7)

This happened naturally and it was clear that they were working together in a military problem-solving manner. Alan was displaying his military leadership as they planned together how to overcome the obstacle. Chris's change in posture externalised the increased self-confidence. He described feeling lighter and it was as if he had shed a burden. Jack was videoing the process and murmured encouragement for Chris to repeat the process, which he readily rehearsed.

As he did so Chris reflected and commented: '*Yeah that took me about 10 minutes instead of 20 years, do you know what I mean, that's so much ...*' *[shakes body out]*. (Session 7). He arrived at his destination point again, having marched purposefully forward.

Chris: *So yeah that's why I'm the man inside the man come forward.*

Alan: *I would say you're in control.*

Chris: *Yeah.*

Jack: *When you look back at the starting point, can you see your goal post there?*

Chris: *[looks over his shoulder to his starting point] Well looking at it from this perspective it's not there.*

Jack: *Mm. Where the starting point was, does that feel further away or closer?*

Chris: *[looks behind him again] It isn't there, not from where I am now. From where I was 10 minutes ago, which is quite interesting, considering it's just a walk, it just feels different just to be able to talk about it now.*

(Session 7)

The conversation continued as they checked out where Chris was. He had experienced a temporal shift. There had been an embodying of this shift and during the process, despite his high level of anxiety before, he had not experienced any tics. The team had checked Chris out and in doing so, reinforced his position. There was also a sense of achievement for Alan and Jack, as they had taken on familiar leadership roles they would have confidently fulfilled in their military service.

Session 8

In the final session the group had just completed the 6PSM and they discussed the trials that Shackleton and his team overcame in their Antarctic expedition. Their thoughts turned to Odysseus and what the dramatherapy exploration has given them.

Chris: *The story – it doesn't deserve anything else, it's got what it is hasn't it – it don't deserve to be altered.*

Jack: *Yeah it's very good.*

Alan and L: *Yeah.*

Alan: *Yeah, that's hope.*

All: *Yeah.*

Chris: *We all live in hope.*

Alan: *You know what we said about prayer and I keep my fingers, not just physically but mentally.*

(Session 8, 739–746)

There was a cohesiveness and resolve in their comments. They were united in hope.

New territory

Session 7

ALAN

In his individual text reading session Alan made a discovery. This diverged from the others. He has struggled with reading since leaving the military. He had to scan-read documents during his military service, under a state of high alert, committing the important

elements to memory. Now normally when he tries to read, he complains of being unable to absorb the written word, becoming anxious and distracted.

You see when I read like that Linda, I can read, it's not a problem ... if I was by myself I couldn't do that. I did this ... Well you know, I'm not stupid, at school I used to do a lot of reading. (Al. Session 5)

Alan sounded surprised and pleased that he was able to read. He had not revealed before that he feels his difficulty with reading may equate with being stupid. He rehearsed reading aloud several times in the session and practised at home. He had been very emotional about this breakthrough, and shared it with Jack and Chris.

Now I found out three weeks ago, that if I read things out loud, I take it in, I'm reading out loud when I'm home by myself. That's how I'm getting through it. Yeah, like you say, I'm always learning something, always learning something (chuckle). (Al. Session 7)

Alan revealed his struggle with reading to others but also the fact that there is a way to learn new ways to tackle a problem. In addition he emphasised that he thought it should be shared through the research: 'You have got to take time to make sure you tell them' (Al. Session 7).

Alan was driven to share his experience of dramatherapy to help other veterans. The others agreed with him.

Overview of IPA results

The IPA revealed participants' perspectives of the dramatherapy, which are discussed in Chapter 6 in relation to the research questions and the other data. Figure 5.7 summarises the key aspects of the dramatherapy that emerged through IPA.

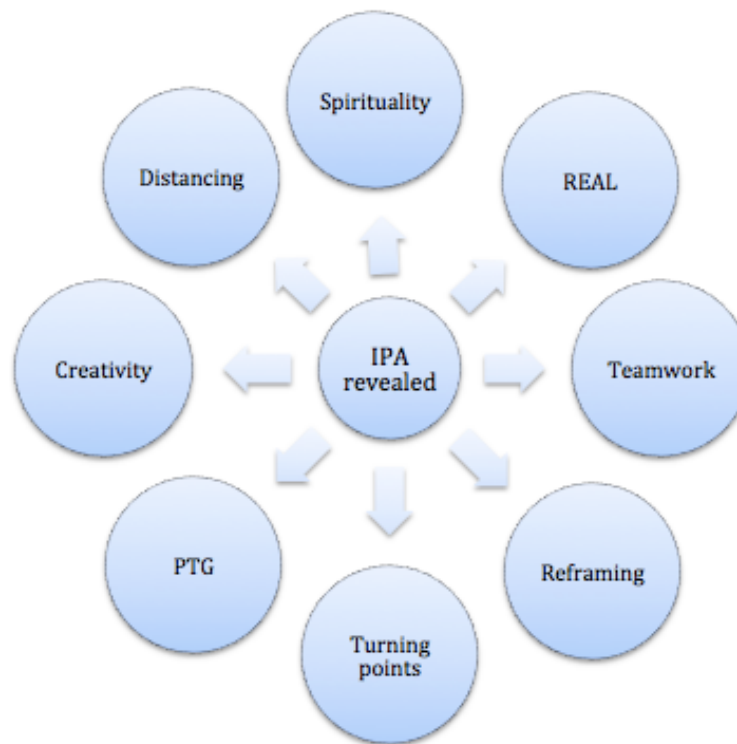


Figure 5.7 Key aspects from dramatherapy sessions revealed by IPA

5.4 Quantitative data results

The scoring criteria for the quantitative scales are listed in Section 3.6.

Participant test results

ALAN: CORE-34

Alan remained above the CORE clinical threshold (Barkham et al. 2011) by the end of treatment. His risk-level increased due to a single incident of anger in a public setting that occurred in his final week of dramatherapy (Figure 5.8). He remained below the clinical cut-off point for risk and his well being improved according to CORE-34 to below a clinical significance rating. His problem level and functioning scores remained clinically significant.

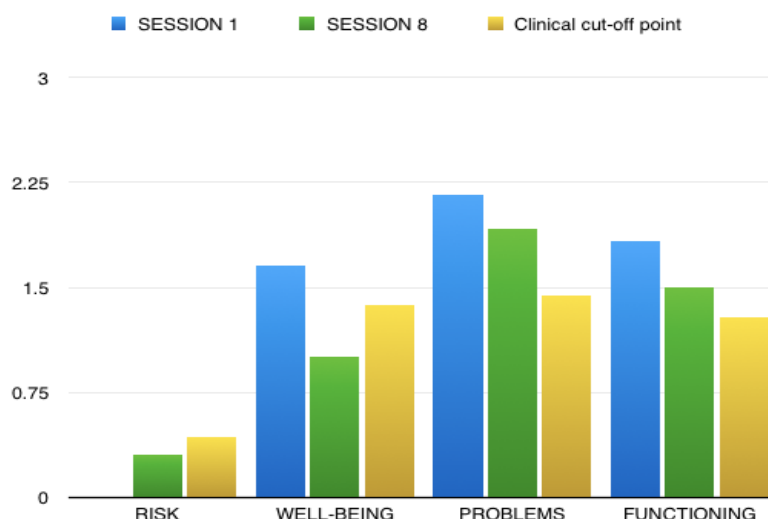


Figure 5.8 CORE-34 test results for Alan

ALAN: CORE -10

Examining the CORE-10, Alan's level of distress fluctuated during the sessions (Figure 5.9) and noticeably increased when Fusilier Lee Rigby was murdered in the UK. He remained within the clinically significant threshold.

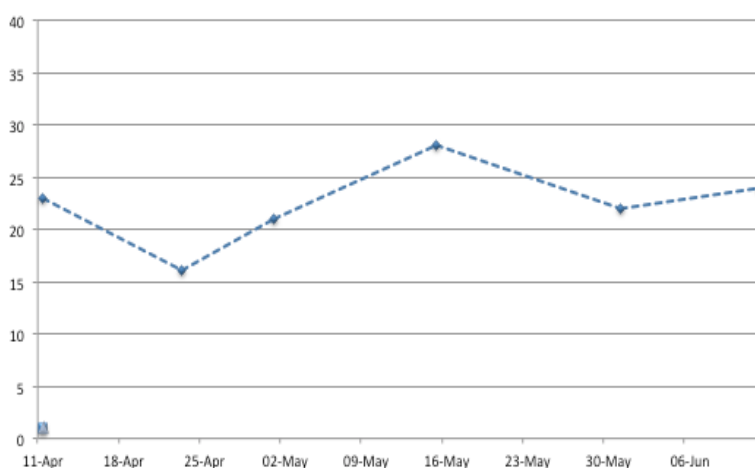


Figure 5.9 CORE-10 test results for Alan

ALAN: SWEMWBS

The SWEMWBS showed a rise of 5 points (Figure 5.10), which is considered just within the threshold for improvement; however he still is regarded as having a poor sense of well-being. His increase in distress in Session 6 correlates with the increase in his level of distress increasing on the CORE-10 measure. The timing of Session 6 for Alan was the day

after Fusilier Lee Rigby was murdered in London and that impact was captured by the rating scale interrupting the trajectory of improvement in well-being.

SESSION		
1	14	POOR
2	15	POOR
3	16	POOR
4	19	POOR
5	23	BELOW AVERAGE
6	17	POOR
7	18	POOR
8	19	POOR

Figure 5.10 SWEMWBS test results for Alan

ALAN: PCL-M

Alan showed a small improvement from 64 in the first session to 61 in the final session for his PTSD symptoms according to the PCL-M (Figure 5.10). This cannot be considered clinically significant when applied to the grading criteria for PCL_M (Wilkins, Lang and Norman, 2011).

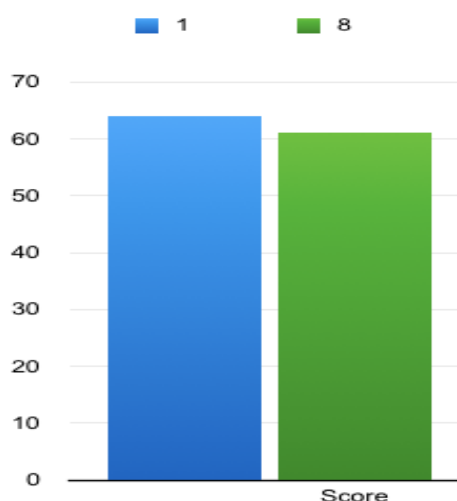


Figure 5.11 PCL-M test results for Alan

JACK: CORE-34

Jack showed the greatest positive change if the first and final scores are examined (Figure 5.12). He remained above the CORE clinical threshold for symptoms, despite his improvement.

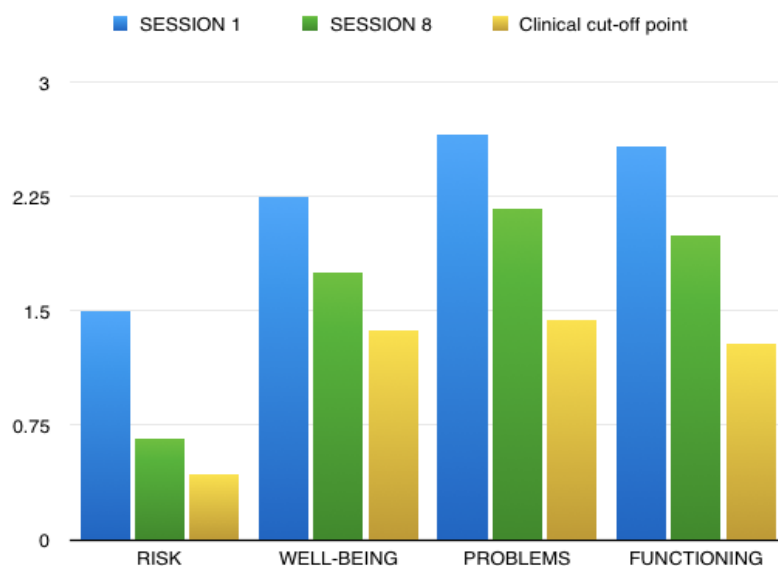


Figure 5.12 CORE-34 test results for Jack

JACK: CORE-10

The fluctuation through sessions 2–7 (Figure 5.13) reflect the emotions Jack experienced as he explored issues that emerged during the dramatherapy sessions and external influences.

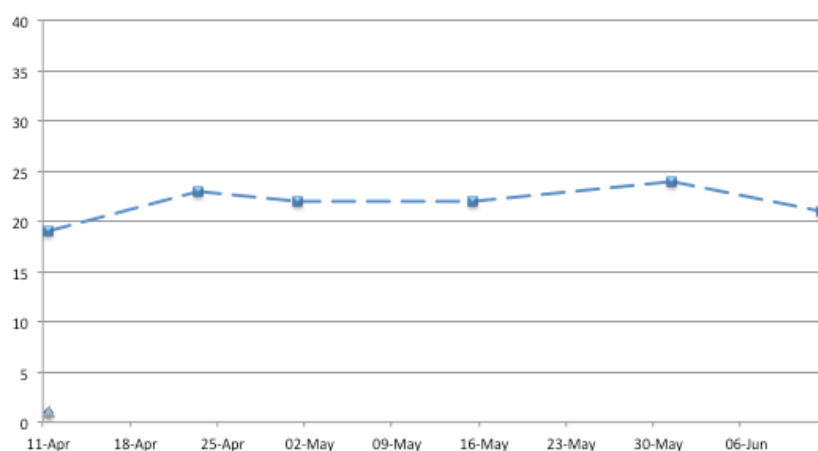


Figure 5.13 CORE-10 test results for Jack

JACK: SWEMWBS

Jack's sense of well-being showed a lack of stable improvement. He did improve overall by 5 points, showed positive change. This still demonstrated that his sense of well-being was poor when compared with the national measures of well-being.

SESSION		
1	12	POOR
2	17	POOR
3	19	POOR
4	12	POOR
5	13	POOR
6	11	POOR
7	15	POOR
8	17	POOR

Figure 5.14 SWEMWBS test results for Jack

JACK: PCL-M

Jack scored 62 in Session 1 and 46 in the final session (Figure 5.15). The decrease in PTSD severity of 16 points is regarded as a significant clinical change. The clinical cut-off for PTSD in the military is 50 and 44 for the general population.

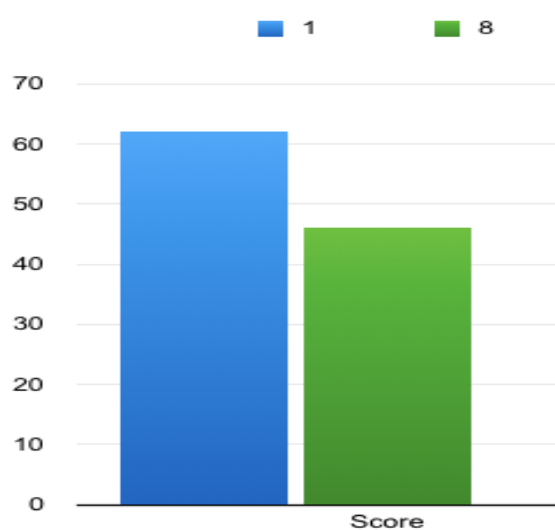


Figure 5.15 PCL-M test results for Jack

CHRIS: CORE-34

Chris remained in the clinically significant scores with the exception of risk where his lack of any level of risk at the commencement and finish of treatment was recorded (Figure 5.16).

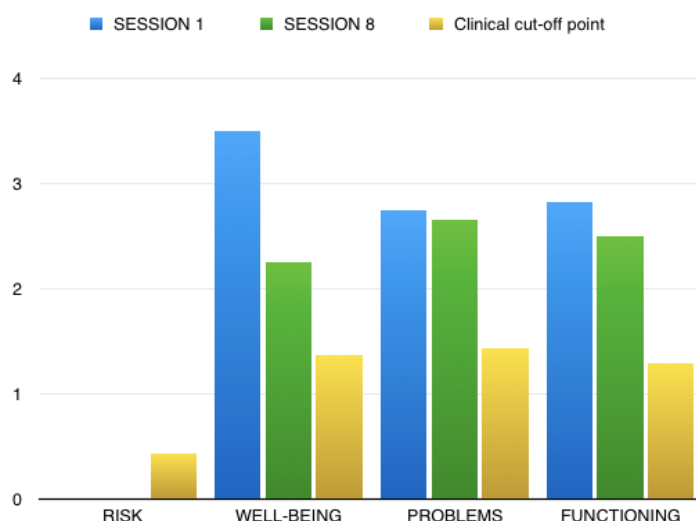


Figure 5.16 CORE-34 test results for Chris

CHRIS: CORE-10

Chris's scores fluctuated widely. He was affected by external events and this measure illustrates how difficult daily living is for him. Session 5 took place at the time of the murder of Fusilier Lee Rigby in the UK. This also had an impact on the scoring.

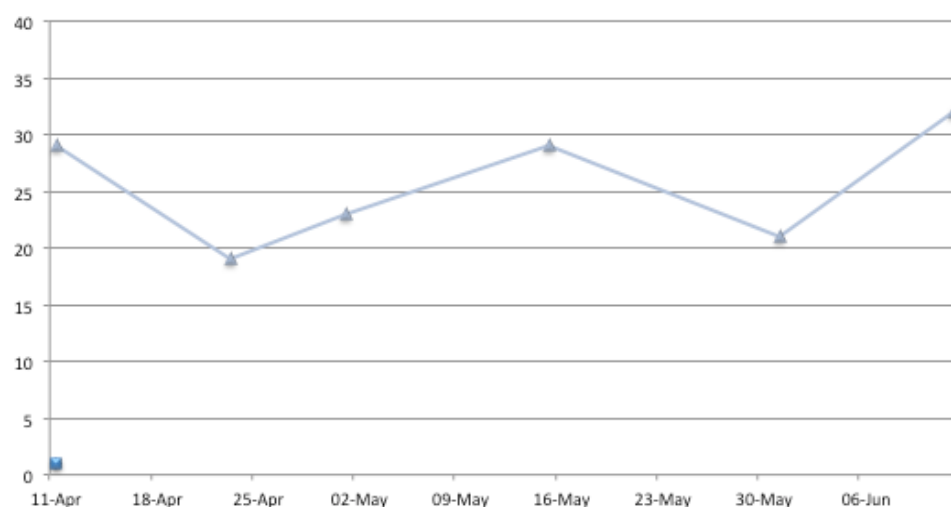


Figure 5.17 CORE-10 test results for Chris

CHRIS: SWEMWBS

Chris showed an increase in his sense of well-being, ending with the score of ‘good’ when fed into the national comparator tool (Figure 5.18). This was not reflected in the CORE-34 well-being element on the final session, which still showed Chris to be above the clinical threshold for a negative perception of well-being.

SESSION		
1	15	POOR
2	19	POOR
3	20	POOR
4	21	POOR
5	19	POOR
6	21	POOR
7	25	AVERAGE
8	27	GOOD

Figure 5.18 SWEMWBS test results for Chris

CHRIS: PCL-M

Chris also showed a small level of decrease in his PTSD symptoms reducing from 67 to 64 points on the PCL-M (Figure 5.19). This score cannot be regarded as clinically significant.

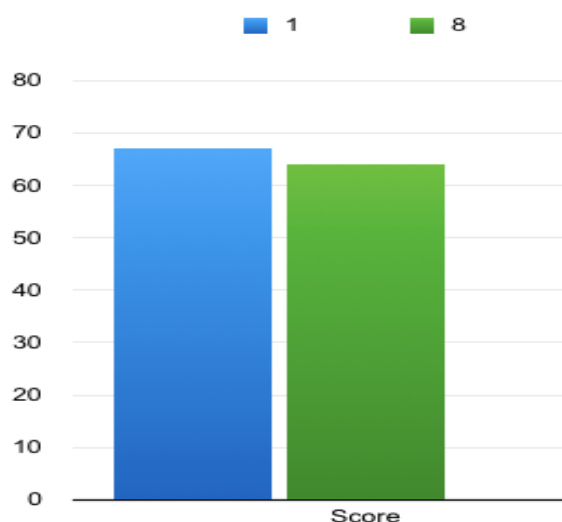


Figure 5.19 PCL-M test results for Chris

5.5 Overview of findings

Qualitative interpretation

BASIC Ph

The grading of the 6PSM using BASIC Ph for the individuals showed shifts in the emphasis on different domains. Overall the results showed positive gains. There was an increase in the use of the imagination for all participants by the final session and a decrease in the negative constructs, with an exception for Jack in his negative social construct, which was balanced out by his score for positive social constructs. Chris's lack of affect in his storymaking was a reflection of the content and his telling of his story.

The 6PSM was subjected to IPA in addition to BASIC Ph and will be discussed further in Chapter 6.

IPA

The particular IPA themes identified and selected for this study represented those relevant to the research questions. The transcripts of all dramatherapy sessions elicited information from the particular methods applied as the participants sought to make sense of their experiences and the dramatherapy processes. There were other themes that emerged through the iterative process of IPA that had to be set aside if they did not shed light on the particular research questions.

Quantitative results

CORE-34 scores

Risk

In sessions 1 and 8 the measurement of risk using CORE-34 was below the level in the normal population for Alan and was absent for Chris, the level of risk improved for Jack and was also below the clinically significant point.

Well-being

All participants showed improvement but remained above the clinical cut-off point, indicating a poor sense of well-being.

Problems

All 3 participants showed an improvement in ability to manage their problems according to CORE-34 although still being considered clinically symptomatic.

Functioning

All 3 participants showed improvement within their scores for level of functioning but they remained within the clinically significant level of impairment.

PCL-M scores

According to the PCL-M scores all 3 participants remained above the clinical cut-off point, indicating PTSD. Jack's score indicated significant improvement according to the measure. Alan and Chris showed a negligible level of improvement.

SWEMWBS scores

Alan and Jack each improved their sense of well-being by 5 points, just meeting the criteria for recognised improvement. They still shared a poor sense of well-being when compared with the general population. Chris made a significant increase in his sense of well-being with an increase of 15 points, moving from the poor to good rating based on national data as seen below this contradicts the score for well-being he recorded on CORE-34.

CORE-10 scores

All participants remained within the clinically significant score.

Summary

No participant deteriorated on any of the three measures, although most changes were so small as to be regarded as statistically non-significant. Jack improved on both the CORE and PCL-M although his CORE score remained in the clinical range. Chris improved the most on the SWEMWBS placing him within the good well-being range in the general population, although this conflicts with the level of improvement recorded on the CORE-34, which showed some improvement but remained within the clinically significant area. Alan showed improvement of well-being, moving out of the clinically significant level according to the CORE-34 on his final session and yet his SWEMWBS final rating was graded as poor compared with the general population.

The results presented in this chapter evaluated the raw data to consider the research questions: What is the participant's perspective on the use of dramatherapy in helping British combat veterans a) to recover from PTSD? and b) to adjust to civilian life?

Chapter 6 synthesises the findings of the qualitative and quantitative data in relation to the research questions.

Chapter 6 The Scenery: Synthesis of Findings

6.1 Introduction

This chapter synthesises and discusses the findings that emerged from the analysis presented in Chapter 5. These findings focus on the research questions: What is the participant's perspective on the use of dramatherapy in helping British combat veterans a) to recover from PTSD? and b) to adjust to civilian life?

6.2 What is the participant's perspective on the use of dramatherapy in helping British combat veterans to recover from PTSD?

The qualitative interpretation indicated the participant's perspective on the use of dramatherapy in contributing to recovery from psychological trauma. Evaluation of the qualitative data identified the dramatherapy methods, which helped towards that improvement in managing PTS (Figure 6.1). The main dramatherapy methods numerically represented are identified in Figure 6.2. The quantitative data provided another perspective to the research questions and is discussed in relation to the qualitative interpretation.

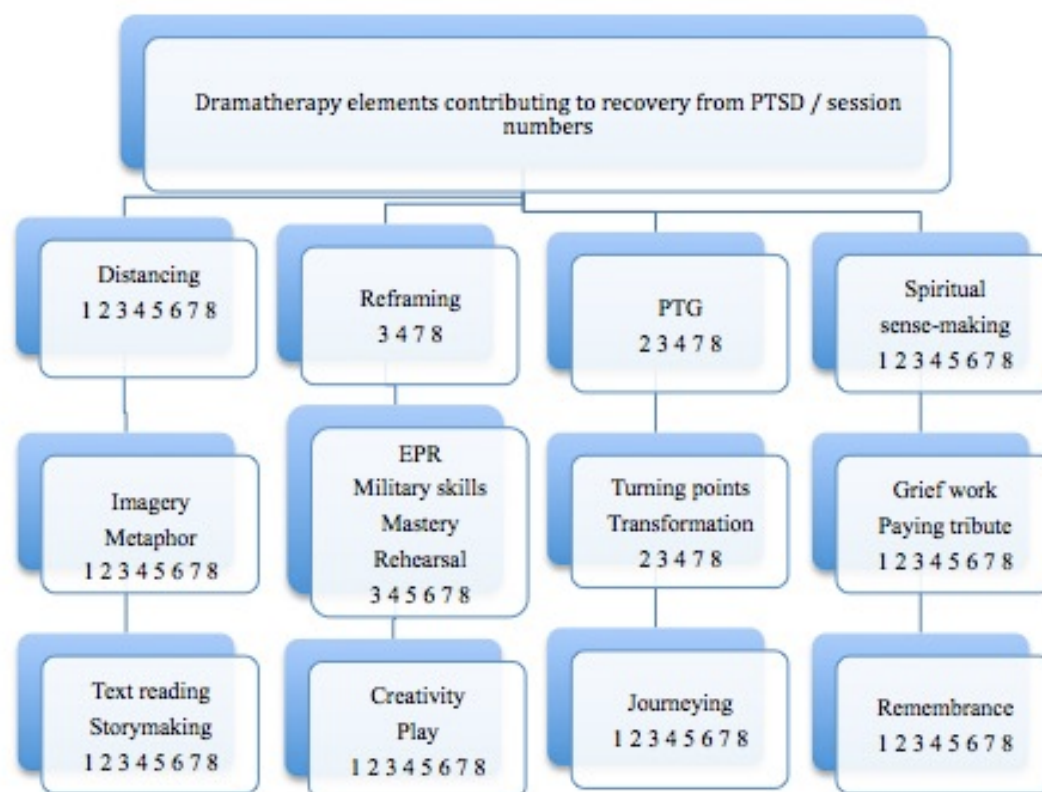


Figure 6.1 Factors identified as assisting in recovery from trauma including session involved

Session	Main dramatherapy method
1	6 PSM / BASIC Ph
2	Communiwell
3	TMOC
4	Story making / Text reading
5	Text reading
6	Text reading
7	TMOC
8	Playing with text and 6-PSM / BASIC-Ph

Figure 6.2 Key to session numbers

Distancing through dramatherapy methods

The dramatherapy sessions did not involve a reconstruction of what had taken place or the use of virtual reality, so the interventions naturally included an element of distancing from the trauma. The dramatherapy methods built on this distancing. This created paradoxically a deeper exploration of the issue. The aesthetic distancing afforded the participants the opportunity to unlock their traumatic memories without becoming overwhelmed. (Landy, 1983; P. Jones, 2008; Johnson, 2010b; Lahad et al., 2010). Chris found aesthetic distancing more difficult to achieve (Figure 5.3). He had a history of dissociation so it was important to proceed at his pace so that he could build up confidence in the method. Under distancing could lead to him being overwhelmed (Landy, 1983; 1991; 1993.)

The 6PSM

The examination of the data using IPA revealed in the 6PSM that Alan chose a real event to represent, unlike Jack and Chris who worked with metaphor. This variance by Alan was interesting as it ran counter to the use of something or someone unknown, or a character, to achieve distancing in the 6PSM protocol. I argue that the framework itself assisted in the distancing and that some stories are just waiting to be told (Gersie and King, 1990). The distancing provided by the framework allowed the expression of the emotion, which had remained frozen in time. The BASIC Ph results had provided information about the coping skills of each participant, which confirmed their ability or difficulty in expressing emotion. The repetition of the 6PSM and scoring of the BASIC Ph in the final session revealed a shift in perspective for each participant. In particular they all showed an increase in the use of imagination and creativity. The influence of the audience (each other) and the participants' growing familiarity with creative methods and the re-use of the 6PSM structure might have influenced that shift, particularly the rise of the social score. Distancing through dramatherapy contrasts with the dissociation that may be experienced by individuals suffering from the effects of psychological trauma. In dissociation the person affected is not psychologically present and either describes blankness or a reliving of their traumatic experience (Herman, 1997; Liotti, 2004). The person engaged in the distancing methods of dramatherapy is actively creating something within a guided framework. This provides the safe container, which is a prerequisite when using dramatherapy with individuals suffering from trauma (Gersie and King, 1990; Winn, 1994; Dokter, 2011).

The communiwell

The communiwell provided all participants with a distancing from overwhelming images and ideas (Casson, 2005). Each participant was able to play with their stories as they moved representative objects around, examining past, present and possible future. There was a risk highlighted by Alan that the colour of certain objects may affect the potential for distancing if it were to trigger a flashback. The deliberate aim of distancing contrasts the dramatherapy protocol with therapy that may seek to desensitise the person with PTS by graded exposure to triggers (Sharpless and Barber, 2011).

TMOC

TMOC used distancing as participants created their own journey through crisis (Turner, 1975; Winn, 1998). The physical journey through the model in session 7 gave the opportunity to use movement to provide distance and to move to a 'safe place' if wished. This physical movement achieved greater distancing than Session 3 where TMOC was mapped out on paper.

Imagery and metaphor

The use of imagery and metaphor within the dramatherapy often occurred spontaneously as the participants searched for ways to tell their stories. Paradoxically it allowed them to voice the unspeakable, expressing what is beyond ordinary language. Storymaking, poetry, 6PSM, the Communiwell, the Odyssey and TMOC all presented the opportunity to use metaphor. The creation of metaphors brought a sense of relief and a way to externalise what had been locked within. In some cases it was metaphor that had been used within their own theatres of the mind. There was an understanding that to externalise those thoughts was a recognised way of voicing trauma (Turner, 1975; Lahad, 1995; Morris, 2014). The language of metaphor proved a predominant way for finding a pathway through trauma. Metaphor is a core concept of dramatherapy according to P. Jones (2007). It does not feature as a distinct process as he places it as a potential element within all dramatherapy core processes. Meta-processes in dramatherapy are identified in a grounded theory study, which highlights the processes commonly used by dramatherapists. This includes metaphor introduced by the client/s (Cassidy, Turnbull and Gumley, 2014). This concurs with my findings. Metaphor was used by the participants to describe traumatic events and experiences, which defied normal language.

Reprising and rehearsing

Text reading and storymaking

The use of *Homer's Odyssey* with the theme of journeying provided an opportunity to identify with characters (Propp, Wagener and Scott, 1969). IPA revealed this had provided a vehicle for comparing some of their experiences with those of warriors through the centuries (J. Campbell, 2008). There was a realisation from all 3 participants that they could decide which roles they wished to explore and which they would discard, leading to a sense of empowerment. Text reading with a play that resonated with the veterans held their attention and improved their recall. They were able to recall the script, discuss it with carers and build upon it between sessions as revealed in the IPA results. This improvement in their concentration increased self-confidence and communication. This was similar to the experiences of veterans in the United States when they explored Achilles (Shay, 2010) and Odysseus (Shay, 2002). In addition to the exploration of the text it opened a path to explore new concepts and possibilities to make meaning of their combat experiences.

Reframing

The participants were able to reframe their personal stories with the illumination provided by a version of the mythical tale, *Homer's Odyssey* (Armitage, 2010). A further dimension was their role as members of the audience (P. Jones, 2008). They witnessed each other's performances, encouraging and at times stepping into the role of a director, or being invited by the performer to take part in the action. In Session 7, TMOC, this was influenced by their military instilled trait of teamwork as they encouraged and supported each other to find a way through to the destination.

EPR

The reconnection with military stances, psychologically through identification with characters in *Homer's Odyssey*, during storymaking and in their 'walk-throughs' during TMOC. They acknowledged previously avoiding reminders of their military service for fear of the traumatic memories associated with it. In the safe arena of the dramatherapy session they rehearsed the positive stances, which were embodied through their years of military rehearsals and action. They projected their emotions and connected to his[s]tories using objects during their communiwell sessions and 6PSM. When some resonance caused anger to arise in the body, the discharge of it through enactment led to awareness that it was something that could be channelled and choices made (Jennings, 2004, 2016).

They were able to play with role characteristics, discarding what no longer fitted and developing useful traits.

Military skills

The motivation that was embedded in their military persona was harnessed through the dramatherapy. The familiarity with the concept of rehearsal as used in preparation for their military roles and operations and their body awareness assisted in the dramatherapy exercises. This was captured in the preparation and performance of their TMOC's and revealed in the IPA. The use of the communiwell and 6PSM assisted in identifying skills and individual strengths to build on in the bid to move forward towards recovery. The use of the imagination gave the participants the opportunity to problem-solve and play with possible solutions. They were able to construct a safe place, in their minds as well as in the room. The IPA results amplified the fact that when they met difficult challenges in their therapeutic journey they rehearsed alternative responses.

Creativity and play

Each session of dramatherapy gave the opportunity for creativity and play. The BASIC Ph in Sessions 1 and 8 demonstrated growth in this area. The introduction of magical thinking and the opportunity to play with 'what ifs' (Bar-Yitzhak, 2010; Lahad and Doron, 2010) provided a platform for the possibility of change. The IPA confirmed that as the participants grew more confident in the process they were prepared to take risks and express enjoyment.

PTG

Evaluation of the qualitative data demonstrated improvement in managing PTS, reframing of personal narratives and the potential for PTG. This contrasted with a difficulty associated with complex PTS, where however distressing it may be; the sufferer finds it safer to stay with the known than risk moving into unknown territory.

Session	Main methods	Alan	Jack	Chris
1	6PSM	x	x	x
2	Communiwell	x	Identifies 'pivot point' possibility of change.	x
3	TMOC	Empowerment 'I feel in control. I can pick the path.'	x	Reflects on Fantastic Reality. 'Can find way forward.'
4	Story-making and introduction to Odyssey text	Discovers can read aloud and retain information.	x	x
5	Text -reading	x	x	x
6	Group text reading	x	x	x
7	TMOC	'I was just travelling thinking what the bloody hell is happening here. And it's changed.'	'that's past, behind - that's where I'm going' looking forward' 'An epiphany.'	'...10 minutes to do what has taken 20 years' 'I'm at the place I should be...'
8	6PSM	'Always learning something.'	I want to be strong enough to walk away' [violence no longer solution].	'Now I'm in control. I'm going to do it for me.'

(Key: A=Alan J=Jack C=Chris x=No turning point noted)

Figure 6.3 Turning points and transformation

In Session 7 the opportunity to build and physically move through TMOC, receiving support from and ability to direct the 'audience' provided turning points for each participant. The IPA extracts in Chapter 5, together with transcripts and recordings of the session, confirmed their experience. The results in chapter 5 and Figure 6.3 identified turning points or transformations for all 3 participants.

Journeying

The overall theme of journeying in the dramatherapy sessions gave an impetus to move forward, exploring new territory, using old skills and developing new.

Spiritual sense-making

Each session revealed a spiritual perspective although this had not been a focus of the dramatherapy. It emerged spontaneously and each veteran expressed different viewpoints, sometimes drawing a clear line between what they termed ‘religion’ and their personal beliefs. The IPA of the transcripts revealed a spiritual dimension as the participants sought to make sense of their personal traumas and loss of others. Whatever the belief there was an expression of hope that things could be better.

Grief work /paying tribute

The 6PSM, communiwell, storymaking and TMOC provided a vehicle for telling personal stories and expressing grief for comrades lost in battle and since. The murder of Fusilier Lee Rigby resonated and magnified their grief for the plight of armed forces personnel. There was also acknowledgement of the impact that their PTS had on families. Sometimes the telling of the story led to reframing and also a release of emotion.

Remembrance

Remembrance was brought to the fore in the 6PSM, communiwell, storymaking, and Homer’s *Odyssey* text. This is a familiar concept to those who have served in the military, with the annual UK Armistice Service and various commemorations of wars. Although there were differing spiritual beliefs, the respectful act of remembrance was shared.

The quantitative aspect

During the period of dramatherapy no participant deteriorated according to the quantitative data. The quantitative scores demonstrated an improvement for well-being and functioning including an improvement in social functioning for all 3 participants on the CORE-34 in Sessions 1 and 8. The SWEMWBS also confirmed this improvement, which indicates progress in coping skills. The CORE-10 results for all participants showed greater fluctuation so no conclusion can be drawn to support or reject the qualitative findings concerning coping skills through the CORE-10. The PCL-M showed slight improvement for Alan and Chris, Jack improved the most falling below the cut-off point for military personnel, although they all remained within the clinically significant criteria for PTSD.

The synthesis

There was a positive trajectory across the quantitative scales in terms of an increase in the ability to show emotion. The qualitative interpretation confirmed that the expression of the emotional aspect was viewed as positive. There were no questions on the quantitative scales relating to creativity or imagination. Imagination and creativity can be thought as contributing to well-being and social functioning (McNiff, 1992; Leckey, 2011). I believe these measures could be considered in relation to these aspects. There were no indicators on spirituality so the increase noted in the qualitative findings could not be supported or disputed by the use of quantitative measures. The small positive changes in the quantitative data compared with the level of improvement revealed in the qualitative data may be a reflection of the complexity of the condition for each participant. Improvement is influenced by the length of time that the person has been affected by PTSD (Johnson and Lubin, 1997; Monson et al., 2008). The quantitative data acted to flag up where an event external to the dramatherapy sessions impacted on all 3 participants, adversely affecting their scores on CORE-10 and SWEMWBS (Section 5.4).

The interrogation of the qualitative data enabled the identification of the impact of the external incident on the psychological state of the participants. The advantage of mixed methods was the combination of both methods provided multiple viewpoints of what was taking place creating greater understanding (Creswell and Piano Clark, 2011). Quantitative data alone would not have provided the context of the change and so the interpretation could have been made without taking into account different possibilities; qualitative data alone would not have recorded the impact of the event across the well-being, problems or symptoms and functioning. It could be argued that the failure for the quantitative results to support the level of improvement demonstrated in the qualitative findings reflected my positive bias in the interpretation of the qualitative data. (Chenail, 2011; Onwuegbuzie and Leech, 2007). I return to that matter in Chapter 7.

One of the originators of CORE (Evans, 2013) asserts that outcome measures are nomothetic, subjecting everyone to the same measuring frame. This does not allow for individual frameworks and nuances to emerge. The measures confine the outcomes to the conscious state. He likens this to '*watching the face not the abdomen when examining the abdomen.*' (Evans, 2013, p.67). He states the case for combining idiographic qualitative data when considering a person's progress. He concludes with reminding the reader that

the domain of psychotherapy is not a technology, rather it is about the arts of relationships with people who are experiencing distress. My study demonstrates that there is a place for nomothetic measures; however the data is enriched if combined with idiographic knowledge. When measurements such as CORE are used the original intention may have been for them to be used as an adjunct to therapy and be interpreted by the clinician as one facet of knowledge about what is happening to the individual. Once those quantitative measures are divorced from the context of the individual therapeutic intervention they may be interpreted in different ways. Each participant in the study showed improvement in the outcome measures (Section 5.4). Chris moved to a ‘good’ rating using the SWEMWBS, though this conflicted with his CORE-34, which remained within the clinically significant range for well-being. Alan’s SWEMWBS results also conflicted with CORE-34 but in the opposite way to Chris’s: SWEMWBS remained in the ‘poor’ range and his CORE-34 rating moved out of the clinically significant range. All participants remained within the clinical threshold for PTSD according to the PCL-M. It was the scrutiny of the individual data, the awareness of the context for the dramatherapy and the complexity of the PTS, and the views of each participant, captured through IPA, which demonstrated positive change in the management of symptoms and a related improvement in the quality of their lives.

6.3 What is the participant’s perspective on the use of dramatherapy in helping veterans to adjust to civilian life?

The qualitative findings captured the perspective that dramatherapy helped veterans to adjust to civilian life. This conflicted with the self-rated quantitative measures, which showed no deterioration but did not demonstrate significant change. The IPA process revealed detailed aspects of the participants’ perspectives of dramatherapy experiences, which were not featured within the quantitative questions (Figure 6.4).

Adjustment to civilian life from military service runs in tandem to recovery from psychological trauma (Iversen et al., 2008). Some military personnel have difficulty in adjusting to life outside military service but not have PTS (Bramsen and Ploeg, 1999; Iversen et al., 2009). If, as in the case of the study participants they do suffer from PTS the difficulty of making the adjustment is compounded (Ozer, et al., 2003; Du Preez et al., 2012).

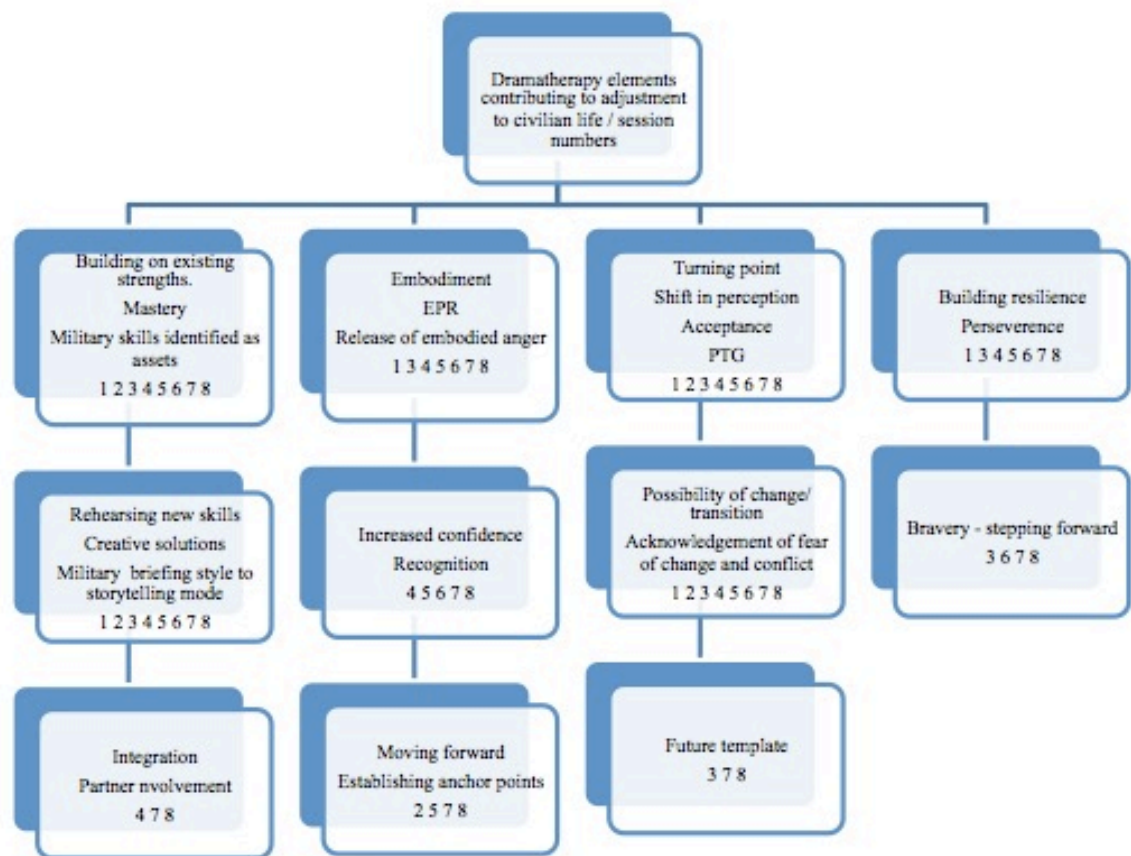


Figure 6.4 The veterans' perspectives of dramatherapy contributing to adjustment to civilian life (see Figure 6.2 for numeric key to sessions)

Building on existing strengths

In all sessions the participants were able to identify positive character traits that had helped them to survive life. These attributes had become buried beneath their traumatic memories. In the individual sessions they began to uncover those aspects. The distancing provided by the framework of the dramatherapy sessions led to an oblique approach to accessing those positive strengths, the engagement of all the senses dampened down the negative self-speak and intrusive imagery. The transcripts of the sessions examined through the IPA confirmed the process.

Mastery

The his[s]tories revealed through the dramatherapy might be of particular significance to how the veteran has managed (or not) his military experiences and return to civilian life.

The unfolding and witnessing of participants' his[s]tories through the projective measures of storymaking, and text reading assisted in reframing how they saw themselves. In the role-playing and TMOC they were encouraged to pay attention to how they felt on an occasion when they had felt good during their service. The recreation of that, drawing attention to how they held their body, their breathing, what they saw, and invoking muscle memory. IPA revealed psychological and physical changes in their appearance and self-confidence.

Military skills identified as assets

The dramatherapy method that uncovered the strongest performance of military skills was the journeying through crisis identified in TMOC in Session 7. As each person reached their own liminal space, they drew from past memories and strength that had been instilled from their military training to propel them forward towards reintegration. There was a shared realisation that the military aspect of their characters need not be discarded. It could enhance what they had to offer in civilian life.

Rehearsing new skills

Dramatherapy provided a different way to explore options for the future using creative solutions according to the IPA.

Integration of self and with others

Examination of the transcripts showed that the participants had shared some of their explorations of text and story with carers and families. This had resulted in laughter and an expression of interest and support. In turn, this encouraged the participants to become more involved with the quest. There was an externalizing of thoughts and emotion within the sharing. This result had not been expected; the sharing of *Homer's Odyssey* text and storymaking preparation opened a communication channel, which had proved fun and supportive. Adjustment to civilian life is eased if people already in that realm support others to make the transition.

Embodiment, positive changes linked to good memories.

The IPA results showed that embodiment was a way of harnessing movement in preparation for moving forward. Rehearsal of these actions strengthened the resolve. If a difficult memory surfaced then the participant sought distance from the role. Due to

childhood abuse Chris feared he could get taken over by a role. He discovered by considering the role as external to him he then identified a characteristic he could adopt and others he could discard. This playing with possibilities provided an opportunity to create pace and space for the adjustment to life as a civilian.

Release of embodied anger

During the sessions each participant acknowledged feelings of anger they carried within. This was most often turned in towards themselves. However Jack recognized for him his flashpoint for anger to erupt and be directed towards others was a very real risk. He had learnt to cope with this by isolating himself, to protect others. The problem was that this self-imposed isolation made integration into normal life an impossibility. In the safe therapeutic space he was able to face and express his anger, through identification with Odysseus. Once this was expressed in a different framework, anger lost its destructive force enabling Jack to consider alternative responses and how he might manage challenging situations in a civilian setting. Chris and Alan did not so overtly express anger and the quest for justice. IPA revealed that these emotions were there and as an audience, witnessing Jack's performance, they were supportive and also exploring their own responses and ways to make sense of them. They shared experiences and suggestions, acknowledging but mediating the potential for violence. It was noticeable they acted as a team to explore solutions rather than the playing out of group dynamics that I would expect to see within the therapeutic setting. The importance of team-work instilled in the military, where it could be a matter of life or death, took precedence for all three participants. A conclusion was drawn that Odysseus's triumph did not come through his violence but when he applied the wisdom of an older man. Anger did not need to be suppressed, leading to isolation, lest it should run amok. Through measured release it could contribute wisdom to life post-military.

Increased confidence and recognition

Increased confidence began with gaining confidence and trust in the dramatherapy process. They were no longer on the battlefield but they were in unfamiliar territory, feeling their way, testing the ground. Those were familiar concepts for them. If they were unsure how to proceed, I would deliberately use terms they were comfortable with as prompts for example 'how will you prepare for the journey?' 'what will you need in your bergen [army rucksack]?' they would then build on this and begin thinking in familiar ways. Skills that

had been hidden by the PTS would surface as they went into problem-solving mode. There would often be a concurrent alteration in body language as muscle memory came into play. The focus on a task impeded the emergence of traumatic memories.

In the first 3 sessions of dramatherapy as they recounted their stories, the participants expressed the lack of recognition they felt since leaving the military ‘sneaking in the back door’. With this emerged a sense of passivity. There was no redress for the anger and frustration they felt about what they perceived as unjust incidents within their military service. The realisation that other warriors, Odysseus amongst them, had experienced these feelings led to expression of the distress it had caused. As they recounted individual experiences, they reflected on the legitimacy of their feelings. Once this happened they were able to find more compassion for their younger selves. In order to integrate into society acceptance of self is part of the building blocks, and lack of recognition leads to a poor sense of self. The gulf between what was experienced in the military and what lies beyond widens. The increase in confidence restored a sense of pride in some aspects of what they had achieved in life. There was acceptance that some of society did recognise the costs of their service and that they have a place as veterans in civilian society.

Moving forward

In Session 2 using the communiwell each participant identified that their situation did not need to be static and there was a potential to move forward in their lives. Jack was excited by the prospect of his ‘pivot point’ engaging with a military term. Alan was relieved that he saw a possibility of change and Chris that he had discovered hope for the future. They were able to literally look at their situations from different perspectives as they changed their viewing angle of their communiwells.

Moving forward was strongly experienced in their TMOCs where they physically pushed through to their destination point. Alan commenting that he achieved in 10 minutes what he had not been able to do in 20 years. There was also an echo of moving forward and resolution in their poems and writing (Appendix 12).

Anchor points

The journeying theme assisted with moving forward from a position of being stuck, not having come home to self, as one of the superordinate themes of IPA indicated. Anchor points are different from being stuck. The participants identified factors that had brought

them to seek help. The looking back and facing these aspects gave the opportunity for them to be addressed. Some material was particularly difficult for each participant. Anchor points, or the building of resources such as safe places and the container and structure of the sessions steadied them if they experienced turbulence during the process. The resources were rehearsed to the point of mastery so that they were confident that they could call on them in their adjustment to civilian life.

Exploring change and transformation

Turning points and conflict

The turning points that emerged in the analysis of the dramatherapy sessions in Chapter 5 are identified as potentially assisting the veterans in their recovery from PTS (Figure 6.3).

The same factors that assist in recovery from PTS contribute to adjustment to civilian life. The realisation of the possibility of positive change occurred during each session of dramatherapy. This instilled a sense of hope; however all 3 veterans also experienced anger and grief for the loss they had experienced not only within the military but also in having the sense of no longer belonging either there or in civilian life. It is often considered that those who suffer from the effects of psychological trauma have lost their place in the world (van der Kolk, 2006). This is confirmed in the IPA analysis of TMOC. For some people with PTS it is necessary to look back and explore their story, the impact and what it means to them, before they are able to move forward. If not, it is as if some force keeps pulling them back to the traumatic incident. This may take the form of flashbacks or dissociation or trying to obliterate the recall through the use of alcohol, other drugs or dependency, or the replaying of aggression towards others or turning inwards resulting in depression and or social isolation. There is a shift towards restoration of creativity and life as the dramatherapy sessions progress away from a view that those who are traumatised *lose their creativity and live as dead* (P.A. Levine 1997, pp.27-42). This shift includes a renewed belief in ability and a growth in self-confidence, which assists integration into life.

Future template

The adjustment to civilian life is not instantaneous. The IPA shows the tenuous journey undertaken. The participants acknowledge that they need things to support them in their

travels. When sharing in their final session they all speak about the need for faith and what that means to each of them. Although there is a dissonance between Alan's, Chris's and Jack's personal spiritual beliefs there is a shared hope that there are resources that will help them to adjust to civilian life. TMOC showed what they were aiming for in their future lives. Some goals remained abstract but some were concrete goals and, returning to the problem-solving skills that had been reawakened in the dramatherapy, they shared plans.

Building resilience

Through the journeying process the participants were able to identify new strengths and recall old coping skills, which had helped them to maintain their sometimes fragile links with life since military service. This had not been so apparent in the first session with 6PSM; however IPA showed that the first session provided a foundation for the following session. All the participants had difficulty with concentration and memory recall, yet were able to remember what had taken place in previous sessions and they chose to incorporate aspects of this into their personal journeys and rehearse outside of the sessions. This points to another aspect that emerged from the dramatherapy involving memory. I will expand on this when I discuss the final research question. It was noticeable that the opportunities for building resilience increased in the final 3 sessions. The IPA suggested that the positive reinforcement and encouragement received from each other contributed to their growth in self-confidence.

Stepping forward and bravery

The long journey (home to self) was a theme that occurred with all 3 participants. The IPA showed that Session 3 (TMOC) was when they first contemplated that life could be different. The resonances with Odysseus acknowledged that it would not be an easy journey. A change in tempo and determination occurred when they commenced the group work. When one faltered the others witnessed and encouraged sensitively. They were using old skills but showing compassion they had derived from understanding what it was to be wounded. It needed courage to emerge from the dark cocoon of trauma after so many years. There was no longer a sense that in order to adjust to civilian life they needed to deny the positive military memories and skills they had, rather that those could be integrated and serve a purpose in their lives now.

Homer's Odyssey text

Exploration of the *Odyssey* text extract and voicing the roles provided a safe arena to explore similarities with the plight of the hero and their own experiences. The IPA captured the reading out of the selected text. The participant was less likely to be overwhelmed or re-traumatised. Revisiting their military personas involved the recall of negative experiences, which is normally a regular experience for someone with PTS, in addition to the psychological scars they often carry physical scars, as in the case of the study participants. They were also able to identify the positive roles that they had encompassed in their military lives. The starting point for this recall was often in the body. Shifting the body into a stance they adopted on the parade ground or on patrol would alter their breathing, eye contact, perceptions and feelings of self-confidence. This assisted with the rehearsal of roles and skills they had identified would help them in civilian life. Trying on these roles for fit and deciding what to discard and what to build on was helpful in rehearsing social and potential employment situations. Sometimes it also led to playfulness and laughter, often a forgotten experience for someone with PTS.

Rehearsal, Enactment, Action, Living (REAL)

This application of dramatherapy arose from the concept of EPR, referred to in Chapter 5, the developmental model now proving useful to be adapted for older people who have had their developmental traits interrupted or disrupted by trauma (Jennings, 2004, 2016). Sometimes the dramatherapy sessions involved drawing the veteran's attention to what was occurring in their body as they replayed or rehearsed a situation. They would select elements they found helpful and act them until they felt they had integrated that role into their every day living. The rehearsal of potential roles resulted in the identification of some unhelpful features discerned by the veterans; these were cast off during a derolling process. The participants expressed a determination to move forward with their lives.

The participants and myself adopted the acronym REAL to represent this process: Rehearsal, Enactment, Action, Living.

TMOC

The use of TMOC proved to be useful in the written form as used in Session 3, when the main feature was as a problem-identification and problem-solving tool. It helped me assess current difficulties and negative and positive factors that were affecting the participants' potential to find a way through the problem. It assisted us to work together to identify possible ways forward. The participants were able to recognise that some of the skills they had learnt in military service were not redundant but could be incorporated to assist them on their journey.

The quantitative aspect

The qualitative interpretation points towards dramatherapy assisting in adjustment to civilian life. At the beginning of this section I refer to research that suggests recovery from PTS goes in tandem with adjustment to civilian life. Yet although the participants have made progress captured through the IPA and BASIC Ph this was not confirmed through the PCL-M. Alan and Chris make minor improvement but remain within clinically significant levels, Jack made a marked improvement and scored below clinically significant for the military PTS though he remains above the cut-off point for civilian PTS. This suggests that a veteran with PTS may be able to adjust to life within the civilian realm and learn to manage their psychological symptoms.

CORE-34 placed all participants below the normal population for risk. This contrasted with some of the qualitative data where IPA revealed impulsive behavior mainly directed inwardly. Self-discipline was apparent in managing the impulses and may be a reason that it did not get captured within the rating scales. The ability to use self-discipline to manage the impulsive behavior and potential for destructiveness is an important positive consideration for integration into civilian life.

Well-being

SWEMWBS and CORE-10 and CORE-34 showed some improvement in the well-being aspects. This indicated a rise in self-esteem, which increases the potential for social integration. This also supports the findings within the IPA and BASIC Ph.

Functioning

The CORE-34, CORE-10 and SWEMWBS indicated an improvement in levels of functioning. This trajectory showed promise and the increased motivation would assist the adjustment to civilian life. The motivation had been captured within the qualitative interpretation so there is a convergence of data.

Problem solving

CORE-34, CORE-10 and SWEMWBS showed an improvement in problem solving and although the quantitative data only suggested a small change compared with the IPA and BASIC Ph the participants' scoring indicated their acknowledgement of the improvement. The ability to be self-reliant improves opportunities in civilian life.

6.4 The veterans' perceptions of the usefulness of dramatherapy methods

Firstly I synthesise and discuss the veterans' perceptions applied to the main dramatherapy methods (Figure 6.5). I then discuss the use of metaphor that emerged in each session. Finally I discuss the idiosyncratic finding that occurred.

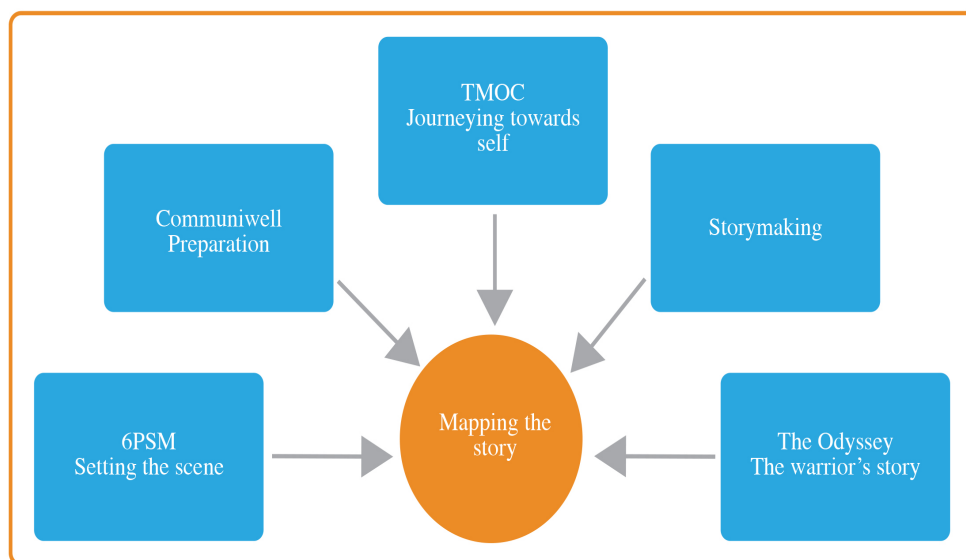


Figure 6.5 The main dramatherapy methods

In Chapter 5 the IPA revealed my interpretation of the veterans' perceptions in answering this research. My interpretations were drawn from transcripts of the dramatherapy sessions and the participants' reflective period immediately following each session.

All the participants felt that the dramathery had been a useful experience. This section discusses their perspectives in relation to each dramathery method. Examples of evidence of this are in excerpts from sessions in Chapter 5.

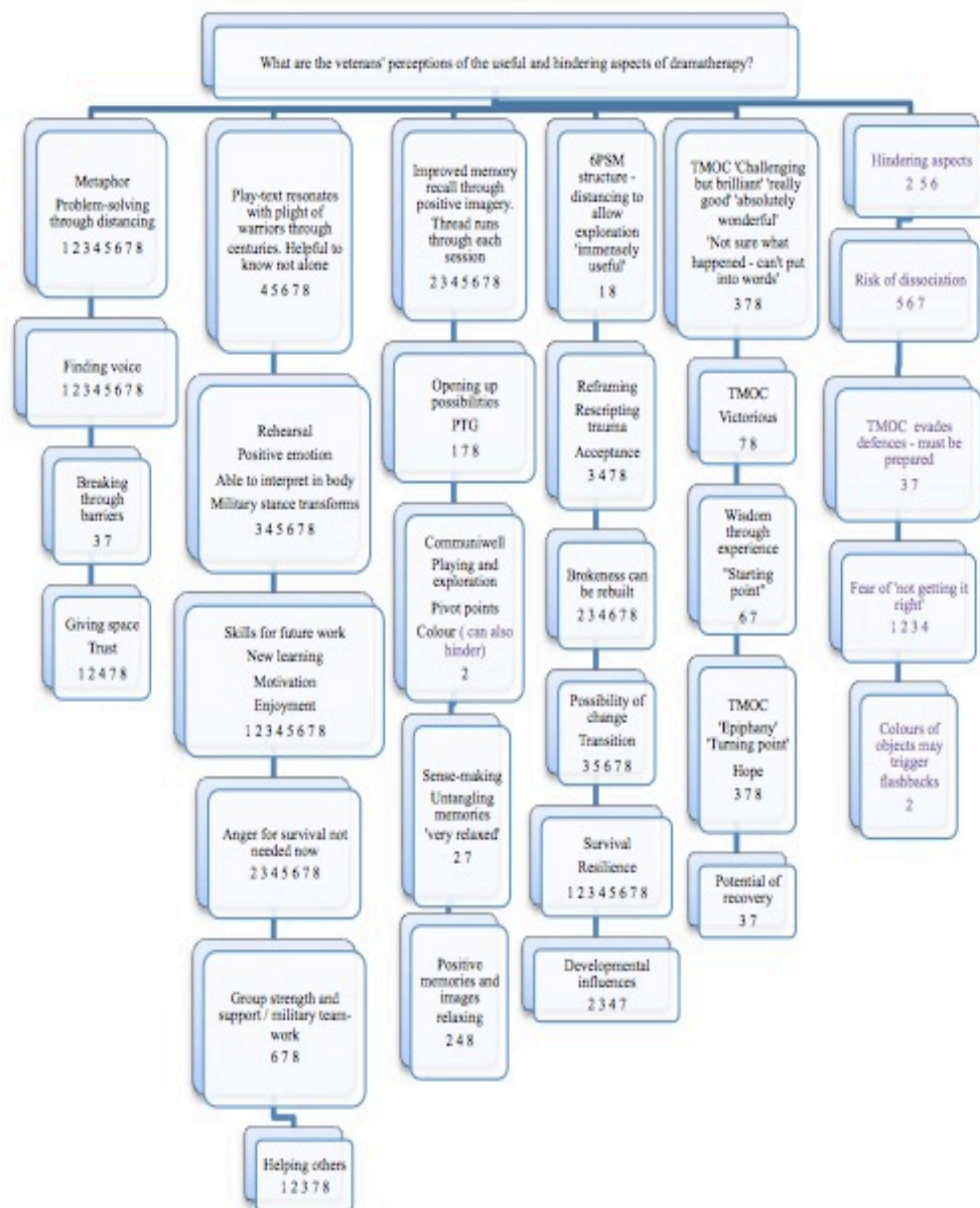


Figure 6.6 Factors contributing to the veterans' perceptions of the useful and hindering aspects of dramathery (see Figure 6.2 for numeric key to sessions)

6PSM – Setting the scene

The individual 6PSM was found helpful by each participant although the IPA revealed this was for different reasons: Alan had found it useful to discuss his feelings around loss and was clear he wanted to tell the story of his friend's death in service, in order to pay tribute and as a mark of remembrance. He was factual in his storymaking. Jack engaged with the creativity of the framework and saw it would be helpful to him in future aspirations. Chris used it to practise negotiations and boundaries, developing his story between sessions. The experience of 6PSM in the first session and their different approaches to creating their stories paved the way for developing their trust in the dramatherapy medium. At the end of the 6PSM they had created a visual representation. Despite all suffering from impaired concentration according to the PCL-M and CORE-34 scores recorded at the first session, they declined the offer of photographs of their drawings, voicing that they would not forget their pictures. This recall was demonstrated in the final session when they were able to refer to the images from the first session without prompting. The fact that they each used the 6PSM in a different way, although following the structure, demonstrates the usefulness of it for assessment. When the BASIC Ph was compared to the IPA data the findings complemented one other. The BASIC Ph gave me the opportunity to discern each person's strengths (Section 5.2).

For the 6PSM used in the final session they elected to draw on a shared large piece of paper. They had become more confident in expressing their stories to each other. They exhibited mastery of the process and enjoyment. The BASIC Ph was able to record the changes that had been made by each person. The marked increase on the positive social scale would have been influenced by them working as a group, witnessing and encouraging each other. There was also an increase in the positive use of imagination. They found they were able to recall the content of their 6PSMs from the first session, indicating that visual recall was strong.

Communiwell

The use of the communiwell proved helpful according to the participants. They found that the opportunity to pick objects stimulated their imaginations as they sought to place themselves in relation to significant others. They reported they liked the fact that the objects were not static and that they could view from different angles, changing

perspectives and use the 3D layers. In addition to this, Chris noted that the empty model with concentric engraved circles could represent the blankness of his mind – spinning it.

TMOC

Individual: Session 3

The individual sessions of TMOC were carried out as a paper-based model. I also asked participants to notice what might be happening in their bodies as they worked through the model. The IPA captured that each participant found this helpful as a problem-solving approach to the recounting of their his[s]tories. I requested that for the first time of using TMOC they chose a minor event so that they could familiarise themselves with how it worked. The distancing through using the use of TMOC provided a stepping back to view the larger picture. Each engaged with metaphor as they went on their journey. There was one potential hindering aspect raised by Alan. He had found it the most useful and yet most challenging therapy he had experienced. The act of distancing paradoxically bypassed psychological defences. He said the learnt skills of evasion that many veterans apply to difficult situations could not operate within this model. In this process it was critical that he was able to introduce ways of moving forward from the crisis. If this is not possible through the identification of positive skills that have helped in the past, the person can rehearse new solutions. The concept of journeying through the model emphasises the moving forward. The therapist using TMOC should be aware of this aspect and ensure that the client is well resourced and has a trusting relationship with them. The therapist must be able to act as a guide to assist the client through the model if needed. Alan experienced muscle memory recall as he worked through his pencil drawing. Jack also showed a kinaesthetic response, as he spoke of his physical disabilities he scribbled harder on the paper and worked quickly which seemed to release tension. He also felt he was able to speak deeper about his experiences whilst looking at the paper. Chris moved from avoidance of a current difficulty, to rehearsing solutions. As he worked through the model, although sitting in a chair the entire time, his body language had altered from poor eye contact, hunched and ticcing to sitting upright, speaking in an animated way and laughing. Interestingly he felt he had to be in a positive frame of mind to undertake the session. In fact he was not in a positive frame of mind when he came in. He had to take that step, trusting that there may be a way forward. He had gone from avoidance of a current difficulty, to rehearsing solutions. The start of the drawing process gave him the chance to transition from his worried persona into another arena, where there was psychological

space to explore possibilities. He commented that the experience had been ‘brilliant’. All had some sense of resolution at the end of the TMOC session. This was portrayed both verbally and as a change in their body language to a more relaxed stance. Once more none felt the need to have a copy of their TMOC, assuring me they would not forget – in contrast with their normal lack of confidence in their recall abilities.

The group: Session 7

The IPA scrutiny showed the participants found the TMOC of value. This was worked through as individuals with the others and myself supporting and/ or being directed into roles if needed. When not fulfilling this role the others acted as the audience. The participants were familiar with the concept of TMOC from Session 3. This time they were to construct a TMOC model of their own choice, to move through as detailed in Section 4.4. IPA revealed that the participants found this process helpful. The concepts of preparing for the journey, receiving the territory and marching forward led to them using military stances and terms. The spontaneous recall of confident, achieving selves propelled them forward.

The opportunity to be directors in their performance of TMOC sculpts; directing myself or the other participants to play roles, led to a transformation of the space and suspension of disbelief (Grainger, 2010; Langley, 2006). Alan, Jack and Chris experienced turning points as they moved towards their destinations. This was manifested by a change of body posture and breathing detailed in Section 5.4, which demonstrated the extent to which muscle memory and psychological recall are entwined. When things were difficult they were able to introduce a concept from fantastic reality (Lahad and Doron, 2010). The premise being that the negative images that they were experiencing during the TMOC were arising from the imagination and so could be challenged with a new story. Alan and Jack were so enthused by their experiences that they encouraged Chris when it was his turn. With their support and encouragement he was able to create and move through the model, trying out different approaches. He also found it very helpful and expressed a feeling of achievement. Each stated they had come a long way in a short time. They shared the importance of working as a team as they would have in the military. The role of the audience of fellow veterans in performing under direction and ‘holding the space’ contributed to navigating the way through the model. When they de-rolled from the performance they decided what characteristics they wished to hold on to.

Overview of the use of TMOC

Preparation and pacing is important in providing a foundation for TMOC. The results were positive but there was a risk of re-traumatisation that needed to be managed (Chu, 2011). The introduction to use of the model through working with a diagram assisted in this preparation. The combined use of this with Turner's Components of Crisis (Turner and Schechner, 1988) gave the opportunity for problem solving and assessment of current strengths and deficits. The physical creating and moving through the model emphasises the journeying process. For the veterans the physical movement appears to have helped them recall how they had coped with challenges experienced in the military. Each reported release of tension as they moved through the model and this was observed by the change in their physical stances (Levine, P.A., 1997). The effect of muscle memory and the effect it can have on maintaining traumatic reactions is a consideration in treating PTSD (van der Kolk, 1994; van der Kolk, McFarlane and Weisaeth, 2012; Rothschild, 2003).

Participants described TMOC as the most useful intervention. Distancing methods require caution because of the paradoxical ability to go deeper into the psyche. This was highlighted by a reflection from Alan (Section 5.2) where he identified the ability for TMOC to bypass defences in session 3, although still regarding it as useful. The physical movement in Session 7 appeared to have mitigated this. It may be that the movement, as opposed to sitting in a chair, gave the option of being in control of the scene. This concurs with the acknowledgement of the usefulness of bodywork in the release of trauma (P.A. Levine, 1997; van der Kolk, McFarlane and Weisaeth, 2012; Rothschild, 2003).

Storymaking

Each participant chose different themes for their individual storymaking sessions. Alan told a tale from his childhood, Jack based his story on Valhalla and Chris based his session on a poem he wrote. Each had spent time in preparation between the sessions. The IPA revealed their creativity in deciding what they wanted to produce. Alan had experienced grief when he reflected on what he had lost to the military although he also found it had made him happy to recall good memories from childhood and he was able to laugh as he recounted his story. Jack was enthused by the process. He found relating the story and expressing his spiritual beliefs helped him to make sense of some things that had happened to him and reminded him of his strengths despite his physical injuries. He experienced a shift in his self-perception and realised that anger was not the only way to express

emotions. Chris had in contrast to the others been nervous beforehand in preparation for the session, wondering if it would be good enough. His poem ‘The Twisted Oak’ (Appendix 12) is a metaphor for all his experiences. He expressed his need for nourishment but also in the session expanded on his hope for change. Each participant said they had found the session helpful as they explored creative responses to their situations.

***Homer’s Odyssey* text –reading**

The exploration of extracts of *Homer’s Odyssey* was a new experience for all the participants. They felt it was a very apt text for them and found it easy to identify with the plight of the warrior trying to return home. The structure of the story acted as a container for their experiences. Reading the roles, initially with me reading the other parts in the individual sessions, was a basis for discussing similarities with their combat experiences. Alan and Jack found reading roles within the group a helpful extension of the work. This contrasted to Chris’s experience discussed in Chapter 5. He became under-distanced and felt the role he played had overwhelmed him. This potentially hindering aspect of dramatherapy was mitigated. An important aspect for Chris was that he was listened to and able to make choices. He was able to negotiate what he needed to do and through de-roling and opting to be a member of the audience until he felt able to take on another role, meant he regarded the session as a positive experience. My therapeutic intervention as a dramatherapist acknowledged the concept coined as *dramatic reality* (Pendzik, 2006). There were times in the process when my role as dramatherapist took precedent over my role as researcher. Flexibility is needed to respond to the evolving nature of the dramatherapy. In this instance it was to support Chris in his decision-making and ensure he remained grounded.

Metaphor

Each participant embraced the use of metaphor in each session. Chris used metaphor most frequently as he sought to tell his story of trauma that began before he had developed verbally. He found it helpful that dramatherapy was a medium where metaphor was used. It is a useful way of providing distancing, paradoxically that allows for greater exploration of potentially traumatic material. The expression and release of emotion is not interrupted by flashbacks or dissociation (Turner, 1975; Lahad, 1995; Mann, 1996; Eberhard-Kaechele, 2012)

Memory

All 3 participants had experienced unexpected memory recall of sessions, such as the 6PSM; the sculpts they constructed on the communiwell; the TMOC; *Homer's Odyssey* text; their storytelling and, in the group setting, each other's stories and poems. Learning that they could recall positive images and memories served as a positive balance against their experiences of intrusive images and traumatic memories. This gave them hope that it is possible for change to occur.

Idiosyncratic result

I have detailed in Chapter 5 the discovery that Alan made concerning his ability to read out loud after not being able to read and retain information for over 20 years. He emphasised the change this has made in his life. Now he enjoys reading, feels able to read to his grandchildren and has increased in his confidence to face new challenges.

6.5 Participants' perspectives on hindering aspects of dramatherapy

Alan identified a potential hindering aspect of using the communiwell. He thought colours and certain objects might trigger someone's flashbacks. He suggested that these objects should not be omitted but that it would be preferable if they were displayed in order, giving the example of all red objects clustered together, so that the person could skim over them.

The other two hindering aspects identified are applicable to other forms of psychological therapy. Alan and Chris identified them as potential issues within dramatherapy.

Alan thought that the questionnaires should be completed at the end of each session to achieve better results; this point was made in Session 8 and Jack and Chris concurred. The reasoning was that they felt better by the end of the session but things may happen before the session, which would affect the score.

Chris thought it would be hindering if he felt that the therapist was not interested or experienced enough to understand and manage any situation that may arise. He also thought it would be important that the therapist understood the use of metaphor and the importance of allowing space for him to think. Chris had experienced his use of metaphor being misinterpreted as schizophrenia in the past and had not been given space to explain his 'monsters' were a metaphor for his experiences and not hallucinations. Chris's history of dissociation heightens his vulnerability; yet with careful structuring and pacing he

showed the greatest increase in his sense of well-being according to the SWEMWBS. Clinical judgement, skills, knowledge and research findings need to be considered when assessing whether someone may benefit from dramatherapy (Grainger, 1999; Casson, 2001; Pearlman and Courtois, 2005). Chris and Alan reflected that the research recruitment poster (Appendix 3) had initially put them off as it showed figures on a stage. They both expressed the view that they would not have wanted to be placed in the ‘spotlight’ and put on a performance, as in the theatre. This was a helpful comment because as a dramatherapist I was blind to how threatening that may feel to some individuals. Some potential dramatherapy methods would not be suited to everyone. The Diagnostic Role Playing Test (DRPT-1 and DRPT-2) (Johnson, 2011) gives comprehensive information about the suitability of dramatherapy for a person and their strengths. DRPT-1 involves a set of a table and chair, with ten specified props, role and topics. The individual is then asked to play three defined characters. DRPT-2 takes place in an empty room, with no movable props the only element specified is there are three characters, and to manage the interactions between the characters, whilst being observed and recorded by the examiner. Miller and Johnson (2012) detail the use of DRPT with combat veterans and there was no reticence in the use of the method. This contrasts to the views of Alan and Chris, amplifying the fact that dramatherapy methods can be tailored to individual preferences.

Jack did not identify any hindering aspects of the dramatherapy, although he thought he was ready for it – if it had been offered to him a few years before he doubted he would have engaged. Motivation and timing are important when assessing a person’s suitability for dramatherapy. It may take many sessions to build trust and resources such as a safe place installation (Lahad and Doron, 2010; Redfern, 2014; Winn, 1994) before moving on to more trauma-focused therapy.

6.6 Unexpected findings

The process of IPA emphasises that the researcher must set aside as far as possible, preconceptions to allow the phenomena to emerge (J.A. Smith, Flowers and Larkin, 2009). Of particular note are those summarised below. Smith refers to the process of the discovery of such gems as *diving for pearls* (J.A. Smith, 2011).

Some unexpected findings emerged:

- Imagery and metaphor improved memory recall.
- Dramatherapy opened up new possibilities in the move towards recovery. These experiences and turning points have been identified in Chapter 5 and Figure 6.3.
- Personal spiritual meaning-making emerged from individual sessions and this was then shared during the group work. Each person was respectful of each other's beliefs, although seeking common ground.
- The group dramatherapy had an additional dynamic, reflecting the participants' military background. Team-working to assist and support each other was apparent from the first group session and reflected the military ethos of 'pushing forward together' and 'no man left behind.'
- Personal spiritual meaning-making emerged from individual sessions and the participants then shared this during the group work. Each person was respectful of each other's beliefs, although seeking common ground.
- Reading aloud the play text for one participant led him to recover his ability to read and retain information.

Reflections on their journey

Each participant spontaneously built on dramatherapy experiences outside of the research. Jack focused on learning more about stories in order to gain respite from his negative thoughts. He reported inspiration for his future career. He also involved his wife and others in his rehearsal and discoveries outside of the sessions. He reported that this improved relationships. He said he had better ways of managing his anger, often adopting the role of someone he admires and using their approaches to manage situations. Alan often used TMOC to problem-solve situations and see if it would work for him outside of the sessions. He affirmed that it did. Chris built on his understanding of the use of metaphors and shared this with others. His journey through the sessions had been difficult but the increase in trust and ability to express himself fluently, encouraged him to seek support to report his childhood abuse. All 3 expressed more confidence and an improvement in their ability to manage physiological reactions, using skills they had first learned in the armed forces. The storying and role enactment in the dramatherapy sessions had rekindled capabilities that had become subsumed under the mantle of PTSD. The dramatherapy sessions provided a safe framework, which reduced the fear of provoking overwhelming traumatic memories (van der Kolk, 2006; Rothschild, 2003; P.A. Levine, 1997; Gersie,

1996). Playfulness and imagination could be engaged to rehearse possibilities (Lahad and Doron, 2010). Each participant reported an increase in their creativity and a desire to share their experience of dramatherapy with other veterans.

The participants thought the individual sessions had been necessary to build up trust and confidence in the dramatherapy so as then to work in a group. They commented that it had been their request to merge into a group and that felt right at that stage (Session 6). They thought it was important that the group was so small. They reasoned that it gave each person the opportunity to be involved and a commitment to attend. They emphasised how helpful it was to work in a group with people they could trust. Initially they only knew each other by sight but the fact they shared common ground as veterans was recognised. Since the dramatherapy sessions have finished they stay in contact with each other and speak of a special bond. They are eager to be mentors to other veterans in any future dramatherapy sessions.

The quantitative aspect of the veterans' perspectives of the dramatherapy sessions

The quantitative results provided measurements that may be considered in relation to the question. The qualitative interpretation indicated that the participants' perspectives of the dramatherapy revealed improvement in the areas listed below. I comment on each of these in relation to the outcome measures.

- *Imagination, creativity and social functioning.* The IPA and BASIC Ph revealed an increase in the use of imagination and creativity and better social functioning for all participants. In this case the improvements on SWEMWBS, CORE-34 and CORE-10 discussed in 5.2 supports the qualitative interpretation of improvement.
- *Memory.* The IPA revealed an improvement in memory, exemplified by recalling contents of sessions and feeding back on them in later sessions, with no prompting. The improvement on SWEMWBS suggested an increase in the ability to think clearly although the improvement across participants was not significant. The PCL-M includes a measure of concentration. The PCL-M showed significant improvement for Jack, the improvement for Alan and Chris was not considered

significant. CORE did not cover this aspect. The SWEMWBS and PCL-M did not have a specific question on memory; the scores contribute to supporting the qualitative result.

- *Problem-solving.* The SWEMWBS has a clear question on problem-solving – *I've been dealing with problems well* (Appendix 4). The increase in scoring indicated an improvement in all 3 participants, confirming the qualitative findings. CORE-10 is negatively phrased in overall terminology compared to the SWEMWBS: *I have felt able to cope when things go wrong* (Appendix 4) and does not indicate the same progress although it does not indicate deterioration.
- *Distancing.* The qualitative interpretation captured the positive effect methods that contributed to aesthetic distancing had from the participants' perspectives. The only question on the quantitative measures that involves distancing is in the PCL-M *Feeling distant or cut off from other people*. This is clearly not the same use of the concept of distance. It is an important symptom of PTSD. I draw attention to it, as although it does not have a correlation with the qualitative findings, it is an area where misunderstandings could occur between professionals of different clinical backgrounds.
- *Physicality.* Physicality in terms of embodiment is not measured on the outcome scales with the possible exception of the SWEMWBS *I've been feeling relaxed*. (Appendix 4). The improvements captured in the IPA and BASIC Ph do reflect feelings of relaxation at times. The PCL-M records physical reactions to a reminder of a stressful military experience, this did happen occasionally in the dramatherapy sessions, however it must be noted that the measures were completed at the commencement of the sessions. CORE-34 has a question related to physical problems and combines a question about tension with anxiety. These outcomes do not provide a distinct conflict to the qualitative findings and do show an improvement trajectory. They provide a small and mixed contribution to the findings on physicality and as such are inconclusive.

- *Anger.* The PCL-M has a specific question on anger and irritability and demonstrated an improvement for all participants. The SWEMWBS and CORE-10 did not include a question on anger. The CORE-34 has a question on irritability and one on physical violence. Jack was the only participant who scored above the normal population on this scale at the start of treatment and had reduced to below the normal population by the end of the dramatherapy. This supports the findings of the IPA.
- *PTG.* All participants experienced PTG according to the qualitative data. The quantitative measures did not have a specific question on PTG. Looking across the quantitative results in Section 5.4 the results are supportive of this concept. They do show some improvement even though remaining within the clinically significant limits for the participants. The fact that the results do not show deterioration and show a move to improvement suggests the potential for PTG (Tedeschi, and McNally, 2011).
- *Recovery of lost skill.* No quantitative measure was able to capture the idiosyncratic finding, which impacted so greatly on Alan when he rediscovered his ability to read.

6.7 Summary of results

The qualitative interpretation indicated that dramatherapy assisted veterans in their recovery from psychological trauma. The rehearsal and reframing that happened through the sessions assisted the veterans' adjustment to living within a civilian society. The journey process of the dramatherapy revealed from the participants' experience helpful aspects that suggest transformation and PTG (Dekel, Mandl and Solomon, 2011). It has also revealed aspects, which were difficult for Alan, Jack and Chris, emphasising the importance of moving forward with caution; care and support were essential.

Analysis of the quantitative data indicated that no participant deteriorated when treated with dramatherapy. Even a small shift in improvement may assist the person to feel better, which appears to be reflected in the participants' SWEMWBS scores. The quantitative

results diverge from the positive perceptions given by the participants. The outcome measures are considered to have good accuracy, as noted in Chapter 3. The dissonance between the qualitative and quantitative data is reflective of what happens within the clinical setting. The outcome scales confirmed the impact complex PTSD had on the sufferer's life. Each participant has had the symptoms of PTSD for more than 10 years and in Alan's case over 20 years. Improvements and change are slow. It may be the comparison of quantitative and qualitative data is like comparing apples with oranges (Philips, 2009). If dramatherapy is measured using quantitative data without qualitative data being collected, the results may not capture the participants' perception of whether the therapy is helpful in achieving psychological improvement.

Chapter 7 Homeward bound: Summary of the study

Adjustment to civilian life for returning military personnel is a major concern and adjustment disorders rank above PTSD in psychological problems veterans encounter on leaving military service as highlighted in Chapter 1. PTS compounds this difficulty and the literature reviewed in Chapter 2 confirmed this. The purpose of this study was to determine the participants' perspectives on whether dramatherapy might assist veterans in recovery from PTS and whether it might also help them to adjust to civilian life.

7.1 Answering the research questions

The quest was to seek answers to the questions specified in Chapter 1. The research questions were: *What is the participant's perspective on the use of dramatherapy in helping British Armed Forces' veterans a) to recover from PTSD? and b) to adjust to civilian life?*

a) What is the participant's perspective on the use of dramatherapy in helping British Armed Forces' veterans to recover from PTSD?

For veterans their military careers had been about moving forward, facing the enemy and overcoming obstacles to reach a goal. This motivation, which was already underneath the surface, was harnessed through the dramatherapy. The exploration of the Odyssey text extract and playing the roles aurally provided a safe arena to explore similarities with the plight of the hero and their own experiences. They were able to reframe their personal stories with the illumination provided by a historical tale. The use of the communiwell and 6PSM assisted in identifying skills and individual strengths to build on and vulnerabilities to address in the bid to move forward towards recovery. The identification of anger, where it arose in the body, and the discharge of it through enactment, led to awareness that it was something that could be channelled and choices made.

- It became clear to all 3 participants and myself that imagery and metaphor improved memory recall, I return to this later in recommendations for further research.
- The participants' view was that dramatherapy opened up new possibilities in the move towards recovery. Their experiences and turning points have been identified in Chapter 5 and discussed in Chapter 6.
- The spiritual perspective that emerged unexpectedly added a further dimension as the participants sought to make meaning of traumatic incidents and the effect it had on them. The IPA revealed that they had thought it helpful to share their beliefs and hopes.
- The group dramatherapy resonated with them. The support and problem-solving together reminded them of teamwork in the Armed Forces. They all shared the view that it would be a useful approach for other veterans.
- The phenomenological mixed methods case study produced conflicting results. If the quantitative data were taken in isolation it would suggest a negligible level of improvement for Alan and Chris. Jack showed significant improvement in his severity of PTSD but all 3 participants remained above the clinical threshold for PTSD according to the quantitative measures. No participant deteriorated during the research study, according to the data.

b). What is the participant's perspective on the use of dramatherapy in helping British Armed Forces' veterans to adjust to civilian life?

The study demonstrated the participants identified positive changes that would assist with integration into civilian life. Of note is that the results demonstrated that integrating aspects of the military persona into life, rather than being an obstacle to integration was helpful. Often veterans have been encouraged to, or they have tried, to put that military life behind them. Indeed in my earlier writing I was a great proponent of *you can't go back* (Winn, 1994). Whilst that still holds as a fact, there was something useful to learn through revisiting and retelling personal his[s]tories. When this was carried out the dramatherapy framework provided a safe container for the memories expressed (Gersie and King, 1990). This controlled way of revisiting old memories through distancing prevented the invasion of flashbacks. The recall of positive military memories and

associated muscle memory brought with it self-confidence. They learnt to rehearse these and new ways of being. The discarding or de-roling of unhelpful or unwanted aspects of character gives a sense of choice and the ability to reframe the story (Jennings, 1992; Landy, 1993; Johnson, 2000). The ability to choose ways of being, realised both through distancing and embodiment demonstrated a way to manage anger and lessen impulsive destructive behaviour. This is recognised as an attribute of the dramatherapy when working in challenging situations (Dokter et al, 2011). The exploration of these possibilities of change, brought in the *what if* magical thinking (Lahad and Doron, 2010) when obstacles threatened to overwhelm. The use of imagination and creative play led to turning points for all participants, reflecting shifts in their perceptions. Their responses and developments within and outside of the sessions revealed through the IPA and BASIC-Ph indicated better communication with families and carers and raised self-confidence. Rather than being subsumed into society there was a stepping forward to take up their places as veterans within society. This needs a 2-way acceptance; society needs to be prepared to accept veterans as much as veterans need to accept they have roles to offer. I am not suggesting we revert to the Ancient Greek ceremony where the warriors on return from battle had to rehearse a ceremony outside of the city walls. It was only when they had performed to the satisfaction of the City Elders they would be allowed back into the city. According to Shay (2002) '*The Athenians communally reintegrated their returning warriors in recurring participation in rituals of the theatre*' (p.230). The study participants are keen to take up their places in civilian society supported by the veteran community. The qualitative interpretation has indicated their bravery, resilience and perseverance to bring about this reintegration. The quantitative results indicate the positive moving forward, although the gradual improvement shown is a further indication, that it is a slow process.

What are the veterans' perceptions of useful and hindering aspects of dramatherapy?

The study revealed the participants' views that dramatherapy could make a helpful contribution towards recovery from PTSD. The IPA captured their perspectives and these were examined in detail in Chapter 5 and Chapter 6.4. In particular they had all experienced an increase in imagination and creativity. This led to a reframing of some of their experiences and rehearsing alternative responses. The rehearsal had reminded them of previous skills. They identified this had led to better problem solving and ability to manage

conflict. They stated TMOC had been of particular importance in transforming traumatic experiences. They all noted an improvement in their memory recall between sessions. They expressed the helpfulness of the final 3 sessions, undertaken in a group. They felt this built on the earlier individual sessions that they said had been necessary preparation. They preferred to think of it as teamwork rather than group as it reflected teamwork within the military. There was a consensus that dramatherapy would be useful to other veterans with PTS. They added that they would like to act as peer mentors to others embarking on dramatherapy. Jack did not identify any hindering aspects. Chris and Alan were concerned for the potential risk that some dramatherapy methods might trigger traumatic memories (p.169). They emphasised it was important to be able to trust the dramatherapist, that she / he were experienced in treating trauma and had some knowledge of the veteran community.

Summary

The research questions have been answered and demonstrate through the qualitative findings that the participants' perspectives were that dramatherapy might assist British Armed Forces' veterans to move towards recovery from psychological trauma and to adjust to civilian life. The quantitative research data showed some improvement, whilst still remaining above the clinical threshold for PTSD as discussed in Chapter 6.3. Alan, Chris and Jack's positive claims about the potential of dramatherapy to assist veterans in recovery from PTS and adjust to civilian life, suggests that for them, even a slight improvement was felt beneficial. This confirms Lloyd et al. (2008) research on the meaning of recovery and detailed in Chapter 2.5 pp.29-30 of this thesis.

The research has addressed the gap in the literature identified in Chapter 1 –concerning the veteran's perspective whether dramatherapy might contribute to recovery from PTS and whether it might assist with integration into civilian life.

The practice-based study has contributed to theory development and offered the veterans' perspectives on the treatment. The key elements of dramatherapy are discussed in the following section.

7.2 The contribution to knowledge

Distancing, storymaking and metaphor

In Chapter 1 I referred to the early use of drama and theatre, assisting warriors in their homecoming recognised the value of drama in the treatment of returning soldiers, suffering from shellshock. Chapter 2 refers to Gersie (1991, 1996) who developed structured therapeutic storytelling that provided a safe container for exploring issues including trauma. Shay (2002, 2010) used plays for veterans suffering from PTS to explore their situations, provide witness to them, and reframe their responses. Jenkyns (1996, 1999) in her seminal work on dramatherapy and the use of dramatic text identifies how drama can be used for containment and distancing. These writings provided a map as I prepared to set off on my quest to discover answers to my research questions.

A key element of the studies, which provided a foundation for my work was distancing through story and metaphor. The use of the communiwell in assessment provided more information about the context of the veterans' PTS, their social networks and hopes for the future, while the distancing provided by focusing on the 3D platform of the communiwell freed them to tell their personal stories. This relates to the work of Casson (2001, 2005, 2014) and his reason for designing the communicube and communiwell. The veterans found it useful and, interestingly, they were able to recall the images of their communiwells, building on their stories throughout the study. The veterans were familiar with the concept of using representative objects to map out military strategies. I assert that this adds a further potential for the use of the communicube/communiwell as a dramatherapy tool suitable for use in therapy with veterans and a useful method from their perspective.

6PSM and BASIC-Ph (Lahad, 1992; Lahad and Dent-Brown, 2011) produced an increased confidence in the participants' abilities. The repetition of the 6PSM in the final session led to reflection on personal beliefs and spirituality. This had also been touched on in the initial 6PSM. This suggests that the 6PSM framework provided a catalyst for a realm not often discussed in UK secular therapy to be expressed. It was a relevant perspective on the journey to recovery as the veterans sought to make sense of their experiences – both their traumatic experiences and what was taking place in the therapy setting. The quantitative

results had not demonstrated the rate of change but did not contradict the improvements captured in the qualitative findings.

The use of the methods outlined above with the distinct client' group of veterans, contributes to PBE.

In the UK there has been an increase in wider society's interest in the plight of the warrior. This in turn has led to the commissioning or reprise of more films, books and plays on the subject. Amongst those are the works of Armitage including the *Odyssey* (2010). The focus on extracts from this text amplified the theme of journeying for the study participants who, as veterans, felt they had not yet come home (to self). The choice of the text resonated with the study participants and they expressed enjoyment with considering the themes. One participant found an aspect of the drama text difficult. He found his voice to reject or choose roles, which resulted in a new feeling of empowerment. The IPA revealed that the use of the drama text might impact on creativity, positive imagination and reframing of traumatic experiences. This concurs with the work of Shay (2002, 2010) concerning veterans and suggests that dramatherapy does make a positive contribution to assisting veterans in their journey homeward.

REAL

Throughout the dramatherapy sessions rehearsal, embodiment and action were incorporated, as the participants engaged in the methods they hoped would assist them in life. They agreed the acronym REAL as a reminder of the components. The study confirmed that the rehearsal of previously held roles could be helpful and the participants found that useful as a counter to some of the traumatic memories that played out in their bodies (P.A. Levine, 1997, Rothschild, 2003). Each one recalled spontaneously the way they had stood, and the pride they had felt, at their passing-out ceremonies. Preparation for military ceremonies involves much rehearsal, so it was not a new concept for them. In dramatherapy they practised roles, de-roling from and discarding unhelpful roles. The identification and use of role acknowledges the work of Landy's (1993) 'role taxonomy'. Rehearsal could also consist of reframing new responses, such as when one participant used it to rehearse alternatives to violence. This was not the same as the 'developmental transformations' developed by Johnson (2000) but as noted in 2.9 there are some similarities in the roots of practice. Once the participants identified characteristics that they found useful they worked through rehearsal to refining and then embodying them. This

would give them a sense of mastery. This process helped in preparation for responding to real life situations, according to the participants. The action took place both in the sessions and between sessions. The physical and inner shifts that took place were reflected in the results in Chapter 5. The concept of REAL builds on Jennings' work on EPR (Jennings 1992, 2004). She has noted that EPR is relevant to adults who have suffered some trauma that has disrupted, or in some cases destroyed, the developmental paradigm. She also believes that in some people who have suffered ruptured or non-existent attachment in childhood there is a case for EPR in adulthood (Jennings, 2016). The results from my study revealed that REAL was perceived as useful to veterans as they made adjustments to civilian life. It was a method they were able to utilise quickly due to their previous experience of the role of rehearsal within the military setting. This develops earlier work (Landy, 1991, 1993; Jennings, 1992, 2004; Dokter et al. 2011) and provides a perspective particular to military personnel building on earlier research by Johnson (1987, 2009, 2010b; Johnson et al., 1996, 2004; and Winn 1994; 2011).

TMOC

TMOC enabled each veteran to experience a turning point in their personal journey. The structure of the model provided a safe container, as identified by Gersie (1991). Through the rehearsal of positive past strengths and problem-solving skills, instilled or built on during military service, they moved forward through their TMOC sculpt. The IPA revealed the resonance of traumatic memories stored in the mind and body. The distancing through the metaphor of TMOC meant the participants were not overwhelmed. Instead they countered the physical and psychological stress response by the rehearsal of reprised and alternative roles. As they travelled through the TMOC a liminal space may be encountered as identified by Turner (1967) and Jennings et al. (2005). At that stage they were able to exercise the *what if* of the imagination and come up with alternative strategies to continue on their journey (Lahad and Doron, 2010). The invocation of this resulted in the veteran's declaration of a turning point.

This concurs with the anthropological view of the potential of liminal space to be a place of transformation. Liminality is defined by Turner (1967) as the space *betwixt and between*, he explains it as a place where one is brought to the lowest, to then experience the humility, sacredness and the raising up. Ritual transformation is beyond the scope of this study, however the concept underpins the potential of what can take place within TMOC.

The use of distancing enhances the possibilities of the transformation as was discovered by the participants, who all regarded TMOC as the most useful method. The paper-based, chair-bound TMOC used in Session 3 created greater distancing. It provided an opportunity to experience the model, to practise and discuss it. It provided a further method of assessment as the participant identified positive factors that help them and the negative factors that kept them within a reverberating spiral of crisis. It also served as preparation for the *walkthrough* (a term introduced by the participants) TMOC. The paper-based TMOC is of value to individuals who may have disabilities that makes physically moving through TMOC impossible.

In particular, the novel use of TMOC was identified by each participant as a turning point in their journeys. All three experienced a shift in their perspective on their personal traumas and identified a way to move forward. This was first experienced in the individual sessions, where the model was paper-based. The use of distancing to identify their journey trajectory prevented overwhelming responses to their memories. They were able to play with possibilities and attend to physiological responses. In the group session TMOC became more abstract as they created and moved through their journeys using cloth and furniture yet, paradoxically, they experienced travelling through their traumatic memories, to turning points. Each participant experienced a sense of being empowered and facing the future with hope and strength. Their perception that TMOC would assist other veterans in recovery from PTS was amplified by their wish to act as mentors to other veterans undertaking dramatherapy.

I assert that I have built on existing theory and my personal practice (Winn 1994, 1998, 2011) to introduce a novel concept in the treatment of veterans with PTS. TMOC addressed the research questions. It was shown through the IPA that the participants' perspective was that dramatherapy could assist veterans in their recovery from PTS. The reframing that occurred during the process led to personal reviews as to how the veterans could take their places within wider society. Most importantly all the participants considered it to be a most useful intervention and one they could use to problem-solve outside of the dramatherapy sessions.

7.3 Critique of the methodology

Mixed methods case study

My reason for using the wrapper of the phenomenological mixed methods case study (Thomas, 2011) allowed for flexibility to respond to unforeseen findings that emerged and were relevant to the research question. In Chapter 3 I explained the use of IPA required the setting aside of preconceptions, therefore what emerged during the IPA process and the results reported in Chapter 5 required that I revisit the review of literature in Chapter 2 and develop this in the light of the themes that emerged through the IPA.

The mixed methods provided a multi-dimensional perspective to the study. My rationale for choosing mixed methods was that the methodological and data triangulation would provide a deeper multi-faceted view of the meaning of the results as described in Chapter 3.5. There was no expectation that the results should show consistency (Guion, Diehl and McDonald, 2011; Denzin, 2012). The different perspectives from the participants derived through the use of multiple methods revealed the complexities of the information acquired from the fieldwork.

In Section 3.3 I explained that on the qualitative/quantitative spectrum my study was weighted towards the qualitative methodology (Teddlie and Tashakkori, 2009). The mixing of the methods began with the formulation of my research questions and their suitability to be answered through qualitative and quantitative research processes. I specified in my research design that I would use concurrent collection of qualitative and quantitative data. This aided the convergence of both types of data (Creswell and Plano Clark, 2007; Yin, 2013). The choice to analyse the qualitative and quantitative data fully before the synthesis allowed IPA themes to emerge across participants. If I had merged all the qualitative data before looking across cases some relevant themes may have receded. The balancing act of maintaining the idiographic whilst discerning superordinate themes is recognised as a challenging aspect of IPA (de Witt and Ploeg, 2006; J.A. Smith, 2011; Wagstaff et al., 2014).

Initially I attempted to mix the qualitative interpretation and quantitative results when considering each dramatherapy session. This proved unhelpful as well as repetitive. It

seemed like trying to mix oil and water, and comparison of data in relation to the dramatherapy sessions was elusive. The self-rated outcome scales were completed at the beginning of each session in keeping with clinical practice. This did not provide a reflection on the session that was to take place. The discussion of the quantitative results in relation to the qualitative interpretation was therefore applied to each research question. The collection of measures at the commencement of sessions was such an ingrained practice for me; it was one of the participants that raised the issue. There is a difficulty with collecting measures after each session. The participants may be distracted by what has taken place, which may interrupt processing. From a clinical perspective I considered the collection of data at the beginning of a session as an opportunity to discuss any changes or concerns so that it is not only a gathering of statistics but also a clinical tool. This raises a consideration for timing in practice-based research. The particular impact of the external incident, the murder of the fellow service-man, was reflected in the quantitative data, but it was the qualitative data which provided further information concerning the negative impact on the scores. This raises the matter of the routine use of outcome scales in clinical practice, once it becomes divorced from the therapist. If the quantitative data was examined out of context different conclusions may be inferred. This may be of particular concern if the person is being discharged following a set number of sessions, which is a feature of NHS services in the UK in 2016. The results would imply that the therapy had not been successful. Although the qualitative and quantitative results did not prove suitable for direct comparison the quantitative measures illuminated some of the findings. The quantitative measures did not show PTG or spiritual growth, as those questions were not asked on the questionnaires I had selected for the study. It was of interest that commonly used self-measures in UK Mental Health Services did not include these elements. In retrospect I would have selected a measure for PTG and one that measures spiritual growth. My defence is that it was only after the analysis of data that these emerged as concepts occurring in the fieldwork. The emergence of these phenomena demonstrated the potential for IPA to uncover the hidden. It was the thick qualitative analysis of the transcripts, which brought those elements into focus. The discussion of the results at the end of this research journey necessitated looking back and reflecting on the meaning that emerged and how that answered the research questions. The participants' experiences of each component of the dramatherapy sessions were examined. How each veteran frames their world influenced their response to the dramatherapy. The process of revisiting the raw data from the IPA as meaning emerged, to check fidelity to the transcripts,

demonstrated that the double hermeneutic circle remained in action (Boone and Richardson, 2010; Finlay, 2011).

The participants

The participants self-selected, no one dropped out and every session was attended. The self-selection from one geographical area was reflected in that they were all male and white British. This is reflective of the demographics of the veteran' community in that area. I have used dramatherapy with female and transgender veterans and veterans of different ethnicity who have served in the British Armed Forces. A different cultural mix may have produced different results. All the participants had experienced psychological therapy although none had experienced dramatherapy. None had received formal therapy for 2 years prior to the study commencing. It had not been possible to gain accurate details of previous therapy, apart from Alan who I had given 20 sessions of EMDR, finishing three years before the research study commenced.

The small number of participants in the phenomenological case study afforded a thorough thick description of the phenomena. My aim had not been for generalisability, as I stated in Chapters 1 and 3. The idiographic nature of the study deliberately placed the individual above the general. It was my intention to make the veterans' perspectives central to the investigation. The multi-dimensional view that mixed methods facilitated was to provide a study that might be useful to dramatherapists, arts therapists and other psychological therapists. They would be able to consider how the clinical methods may be used with individuals and groups they are working with. Non-therapists as well as clinicians would be able to consider the information that emerged from the qualitative data and consider it alongside the commonly used self-rated measures within this treatment group of the CORE-34, CORE-10, SWEMWBS and PCL-M.

Dramatherapy methods appraised

The dramatherapy methods and tools are elaborated on in 7.2.

6PSM and BASIC-Ph

I selected 6PSM and BASIC-Ph as an existing, well-tested assessment method. It also meant that the dramatherapy commenced with a story and creativity. Although the 6PSM was a new experience for all participants, they engaged in the process and showed a sense

of accomplishment in their stories. The BASIC-Ph captured their personal areas of strength and the changes that had occurred between the first and final session. The IPA revealed their experience of the process and how they thought it might assist other veterans. It was noticeable that all three participants referred back to the stories they made in their 6PSM in other sessions. The images and metaphors remained when usually their short-term memories were quite transient. All the participants commented on that and regarded it as a positive aspect of the method.

Communiwell

The use of the communiwell to identify the past, present and future was enhanced through the use of IPA. The transcript captured the metaphors used within their personal stories and the analysis revealed the many layers of story in addition to how the participants regarded the use of the communiwell. It emerged that the random collection of objects to use on the communiwell might trigger flashbacks. This did not happen but was identified by a participant as a possibility. He thought that those objects and colours should not be removed but instead presented in such a way that they could be passed over. I have changed my presentation of objects based on the feedback. Avoidance can be a problem for people suffering from PTSD but this change of presentation of objects allows for client choice. The perspective shared by the participant contributed usefully to my practice.

TMOOC

The sessions had been designed to amplify the theme of journeying. TMOOC carried on with this theme. My decision to use the TMOOC drawing model in Session 3 served as an introduction to the model. It did not preclude the use of imagination for the participants to build on metaphors and experience physical responses to their recounted stories. It could be argued that elements of TMOOC and the problem-solving approach are akin to CBT. I assert that although there are cognitive elements, even in the TMOOC drawing, imagination, metaphor, enactment in the mind and physiological responses are at play and the excerpts and discussion in Chapter 5 and 6 illustrate this. TMOOC was most identified by the participants for turning points and reframing their stories. They expressed strong convictions that it would benefit other veterans. In the group session of TMOOC the ‘walkthrough’ was sculpted and implemented by each individual. They then chose whether they wanted any of the other participants, or myself to accompany them on their journeys. The IPA captured their perspectives that the experience for each of them had been positive

and their recommendation that it be used for other veterans. The veterans chose to record the walkthroughs for their own use. The video camera was left running and became forgotten about as they proceeded with their sessions. It gave more information about their EPR. In future research I would recommend that video recording be considered in addition to verbal analysis. It was outside the scope of this study.

Storymaking

The dramatherapy part of Session 4 built on the process from the previous sessions, but as I explained in 4.4 the brief was very open. The invitation to bring in a poem, story or object that resonated with them, provided rich material. I had been concerned that they might regard it as homework, with negative associations or forget. In fact all participants enjoyed selecting something to bring and sharing in the session. I had intended it as a warm-up to the play text reading and it did serve in that way. It also added further to the process as stories were told with confidence and playfulness. Rather than see the preparation at home as burdensome, their perspective was that it had been enjoyable as they thought about what they could bring.

The Odyssey text reading

I chose the Odyssey play-text to reflect the theme of journeying that underpinned the study. Shay (2002) had also used it in his work with veterans recovering from trauma. I had selected the passages for the text reading. This was so that the participants would be reading the same material and also to ensure that the passages chosen were not very graphic as some scenes are particularly detailed concerning slaughter. No participant was familiar with the story of the Odyssey, so when I had spoken with them about elements of the play, I gave them an audio CD of the play. It could be argued that to select the passages explored in the research was an act of censorship. I mitigated against that by giving them access to the full play, to use as they chose. All went on to explore the text further. If I were to use cooperative inquiry in the future, then the use of the play-text would be a mutual decision (Heron, 1996; Reason and Riley, 2003). I considered that some people have difficulty reading and that can be a source of embarrassment for them. They do not always want to disclose that difficulty. I always ask whether they would like to read a part or do they want to listen to me reading all the parts. In the study all chose to read parts.

Journeying

The choice of the underlying theme of journeying provided a structure for the study. It might have influenced the sense of moving forward towards recovery, which was revealed in the IPA. A different focus or one where participants bring whatever is around for them, might have produced different outcomes. A dramatherapist from a different professional background, different gender, culture and different experience with the veteran client group, might also have affected the participants' perspectives.

Individual therapy to group therapy.

The move from individual sessions to group work was not part of the original methodology. However as I highlighted in Chapters 4.3 and 4.4 it is not an unusual occurrence in UK NHS services. My response as the dramatherapist to agree to the participants' request was in keeping with my clinical practice. My response as the researcher required further thought and consultation with my academic supervisors. I reflected that the study was to investigate the participants' perspectives of dramatherapy. The participants indicated that they would benefit from working together. The dramatherapy methods were suitable for individual or group use. In 5.1 I explained how the IPA examined the individual responses before turning to reflections arising in the group. The reflections on the sessions were made individually, so the possibility of a group member becoming dominant or another becoming inhibited and influencing the discussion was reduced. Each participant thought it would be important for the veterans to have the opportunity to experience individual therapy first in preparation for moving into a group. There were no comparative studies so it was not possible to say if all 8 sessions had been delivered as individual therapy or all 8 sessions delivered as group therapy, that the participants would have had different views. The flexibility of moving into group therapy demonstrated the important point, particular to the veterans and discussed in Chapter 5.3 that teamwork to move forward was prominent. The change was also a reflection of the movement towards collaborative inquiry (Guba and Lincoln, 1989; Payne, 1993; Heron and Reason, 1997; Heron, 2001b.) as the participants engaged with the dramatherapy to explore their perspectives on whether it would help veterans in their recovery from trauma.

IPA

The IPA generated 75 hours of recordings, which demonstrated a healthy amount of data considering the small sample size. The iterative process of performing IPA meant a continual revisiting to the recordings and transcripts as part of the hermeneutic circle. I

attended IPA basic training and then a master-class. I was also a regular attender at my regional IPA group and on the IPA on-line forum. Transparency of the process was maintained through ensuring a clear audit trail was in place. This was confirmed by an external audit and through the successful operation of the hermeneutic circle, during the analysis.

J.A. Smith, Flowers and Larkin (2009) assert that IPA is a creative process and not a matter of following the rule book, criteria that suits one study for validity may not suit another (p.184). Its idiographic nature makes IPA a flexible way to analyse data. Within that flexibility are the methods described in Sections 3.7 and 5.4 above. It is those methods that provide the rich analysis and allows the phenomena to emerge. The published examples of IPA and theses have been mainly based on interviews although this was not a requirement. Through the IPA Forum I questioned whether IPA was indeed suitable for exploration of live therapy sessions. J.A. Smith, in his reply (personal communication April 2015, Appendix 10) stated that if I felt there was data within live sessions and post-session reflections which would help me get at the participants' perspectives then IPA was suitable. Trusting in the IPA process allowed themes to emerge I would not have predicted. This also demonstrated that the *bridling* of previous experience referred to in Chapter 3.3 led me to be open to new possibilities. The process of setting aside preconceptions meant that some relevant literature only emerged after the IPA and this formed part of the discussion in Chapter 6. (This is expected in IPA). Chapter 2 focuses on the literature that led me to formulate the research questions.

My interpretations were shared with the participants, who stated they were fair and accurate. They understood that it was my interpretation of their perspectives, concerning the research questions. There is a debate whether member checking is appropriate, as the participants remain in the natural state, whereas the IPA researcher is delving beneath the surface (Campbell and Scott, 2011; Larkin and Thompson, 2012). I balanced that concern, with the fact that the thesis would be available on-line at a later date. Ethically it was important that there would be no misrepresentation or misunderstanding. The readers of the study will bring their own lens of understanding, depending on their profession, personal schema, culture, view of the armed forces and the arts. This is referred to as the triple hermeneutic (McFarland, L., Barlow, J. and Turner, A., 2009; Rizq and Target, 2010; Kirkham, Smith and Havsteen-Franklin, 2015). The reader's interpretations will not share the context of being present with the participants and observing intonation and body language, nor have been privy to the many aspects shared but not relevant to the research

study. I have sought to honour the participants' perspectives, whilst being respectful of matters that were ready to be witnessed and those that were not.

7.4 Limitations of the study

The researcher/dramatherapist

In Chapters 3.3 and 6.2 I discussed the potential for bias in the role of researcher/practitioner; participant/observer (Finlay, 2014).

My style of working therapeutically is to maintain a hopeful stance, whilst not discounting any of the turmoil, fear, anger or other emotions, which might be experienced by the individual (Seligman, Rashid and Parks, 2006). Conducting the study as the researcher /dramatherapist proved a challenge. There were times when it could be said that I put my position as dramatherapist ahead of that of researcher. I have been open about the time when I was concerned about the potential increased risk from a participant in response to the murder of Fusilier Lee Rigby. My priority was to assess the safety to him and others. Professional responsibilities and ethical issues will impinge on the role of practitioner researcher. My involvement with the dramatherapy process could have led to me missing some aspects that a researcher purely acting as an observer would have captured. The positive attitude in my interactions with the participants could have increased the risk of bias. To maintain integrity and transparency I utilised reflexivity; clinical supervision; academic supervision and peer supervision as discussed in 7.7. It might have been easier to analyse the transcripts arising from the dramatherapy sessions if I had not been the practitioner. Listening to the session transcripts 3 or 4 times during the analysis, felt as if I was once more in a therapy session. The meticulous reviewing process of the hermeneutic circle, IPA training and the peer review through presentations at IPA forums reduced the risk of bias. The methodology of IPA with the action of 'bridling' referred to in Chapter 3.3 – reining in my preconceptions and waiting for the phenomena to emerge – lessened the potential for bias (Dahlberg et al. 2008). An audit trail of the IPA (Appendix 11) was carried out by a psychologist experienced in IPA in order to affirm the correct steps for IPA had been followed (J.A. Smith, Flowers and Larkin, 2009). I did not have any co-worker or assistant within the sessions. This reflected my normal clinical practice with veterans, governed by the availability of resources.

Prior knowledge of the study participants

There is a risk that the participants exaggerated the usefulness of dramatherapy to support me in the research process. The depth of material expressed in the sessions would suggest this did not happen. It could be argued that the halo effect (Koch and Forgas, 2012; Forgas, 2011) influenced the qualitative findings. The participants had prior knowledge of my clinical work and an expectation that the interventions would be beneficial. Equally my positive regard for the participants may have led to a positive bias in my selection and interpretation of the data. When this was raised with them, they expressed the view that because they knew me it was easier to be open and frank. I balanced the criticism of bias with the fact that my position within that community of veterans gave me a privileged position to gain data for the research.

Time limitations

The dramatherapy was limited to 8 sessions for the purpose of the research. This may not reflect the period required for assessing and treating someone with PTS who is new to therapy. The sessions had a built-in reflection period so lasted more than the standard hour common in UK psychological therapy services. The limitation in number of sessions contrasts with DVT where the client may be engaged in the dramatherapy process for one session or many years. In any case someone participating in DVT will have at least several verbal sessions beforehand, as an introduction to the method (D.R. Johnson, 2009b). Brief dramatherapy sessions are not uncommon (Karkou, 2010; Gersie, 1996).

Strengths and weaknesses of the study

From a clinician's perspective they will consider whether it will be useful with certain veterans. Veterans might decide that all or some aspects may be helpful to them. The variables are many: cultural difference, the particular dramatherapist, nature of the PTS presentation, age of the veteran, experience of therapy – to name a few. The veterans' generosity in participating in the research and agreeing that all material in the dramatherapy sessions could be included, provided information not previously published on the dramatherapy process with veterans.

7.5 Recommendations for clinical practice

Dramatherapy methods

In Chapter 1 I referred to the call for a treatment manual for arts therapies (Foa et al., 2008) and the counter-argument pointing out the risks of a formulaic approach to psychotherapy (Lambert, 2013). The clinical methods I have used in this study have been developed to take the veterans through the process of journeying towards recovery. It includes assessment tools and I recommend that a similar order be used. If it was taken out of order and, for example, TMOC used first this may overwhelm the client. The dramatherapist should be flexible and if the assessment process suggests the person is at risk of re-traumatisation attention should be given to strengthening coping resources first. A dramatherapist must adhere to their professional code of practice (Health Care Professions Council, 2013). They must be trained and confident in the use of dramatherapy with individuals experiencing psychological trauma and have suitable clinical supervision arrangements (Lahad, 2000; P. Jones and Dokter, 2008). If these criteria are followed dramatherapy is considered a helpful intervention by the study participants in the treatment of PTS and in their perspective it can assist in recovery, adjustment to civilian life, the management of anger, creativity, the reframing of personal experiences, and improvement in relationships and employment prospects.

Training implications

Dramatherapy trainings are set at postgraduate level. They train the student dramatherapists to work across a variety of settings and all age groups. The fields in which dramatherapists work may be education, health and psychological health, social care and coaching. In any of these settings they may come across individuals suffering from the effects of psychological trauma. The current world situation, with increasing terrorist threats, refugee crises, war, and all forms of abuse, makes this more likely. In order not to do further harm to the recipients of therapy or put themselves at risk of vicarious traumatisation or burnout it is an imperative that the dramatherapist undertaking this work is adequately prepared. The UK Health Care Professional Council (HCPC) registration requirements make it clear that individuals must not undertake practice they are not trained for. I recommend that the training establishments for dramatherapy consider whether they should incorporate psychological trauma training into the syllabus if it is not yet included.

Dramatherapists who are already qualified should ensure they have the skills to undertake dramatherapy with individuals who have experienced psychological trauma. All practising dramatherapists need to be up to date with safeguarding protocols so they are equipped to take appropriate action if the need arises.

7.6 Recommendations for further research

The small sample size was chosen to enable an in-depth exploration of phenomena in order to answer the research questions. Further research of the clinical structure used would provide a perspective on whether the findings could be applied in other dramatherapy settings, either with a similar client group of veterans or with other individuals with PTS.

Veterans with complex PTSD often require long-term assistance from mental health services (Gerger, Munder and Barth, 2013; Royal College of Psychiatrists, 2013). A longitudinal study where dramatherapy is used for stabilisation prior to other forms of therapy or to assist in the recovery pathway would provide further perspectives on what it might contribute to improved mental health amongst the veteran community.

Neurobiology was excluded from the research, yet the finding about improvement of memory recall between sessions warrants investigation into the use of positive imagery in memory recall in PTS. The idiosyncratic discovery of the ability to read text out loud and recall content suggests an improvement in concentration. This has continued to improve with rehearsal post-therapy and 2 years later Alan reported he has regained the ability to read silently. The testing used in this study was not suitable to capture physiological data and was beyond the scope of the research, but may have uncovered important aspects to be pursued further.

A study of dramatherapy and the potential for PTG might have something further to offer. I would have used different outcome measures to examine this aspect (Dekel, Mandl and Solomon, 2011). In keeping with the phenomenological interpretative case study these issues emerged during the study and analysis of results and had not been predicted when making choices for the study design. The universal measures used in my study were symptom based and part of a dataset required by the NHS at the time. The qualitative findings revealed that the participants' personal assessments of what constituted improvement for them were at odds with the quantitative results. Future research might use

recovery focussed quantitative measures. It is possible that residual symptoms and vulnerability arising from traumatic memories would remain. What is of importance is how the individual adjusts to live what they regard as a fulfilling life.

The research participants engaged with and contributed much to the research process. I am confident that a cooperative inquiry would add to the theory building process of research. Payne (1993) recognised a trajectory in her personal development as a researcher /practitioner. The development as a researcher brings the confidence to work in cooperative inquiry. Reason and Riley (2004) emphasise that the process of cooperative inquiry preserves the self-determination of the participants, as research done with, rather than to them. Veterans often refer to feelings of powerlessness. Within my study they grew in self-confidence as they reflected on the sessions during IPA. Cooperative inquiry would have the potential to increase this and capture what is really important to the individuals.

7.7 Personal Reflections

At the start of this journey, the guidebooks and maps had some information to help plot the course and provide some anchor points. Some preparation took place but the advice was to hold back on what was already known and be prepared for new or unexpected sights and turns along the way as we travelled together in a foreign land seeking our destination. Those who had gone before gave our compass bearings to us. They put in appearances throughout the mission, both in the planning, travelling, and in helping to making sense of what we found. Those who had gone before were varied – historians and writers, providing an insight into the challenges that those who had suffered the effects of battle from ancient to modern times experienced. Those people are referred to in Chapters 1 and 2. The design and plan for the journey detailed in Chapter 3 assisted in sense-making of the experiences, so that they could be shared with people researching their own routes. The phenomenological aspect, waiting to see what would emerge along the route to illuminate the discoveries, was counter-balanced by the completion of paperwork to provide facts and figures to weigh up alterations that may take place in the psychological state of my travelling companions. The story that would emerge, particular to that individual, yet sharing some common territory with their fellow veterans, was held together in a wrapper – the case study (Thomas 2011) so their story would not get lost in the telling. Dramatherapists, anthropologists and a storyteller provided the dramatherapy tools and

methods that formed the plan explained in Chapter 4. These could cause a sudden halt, propel us forward or provide the distance needed to take a view and gather strength. My fellow travellers would reframe memories and feelings, using old skills to rehearse new solutions instead of being overwhelmed by the enormity of the task. They taught me new ways of viewing the journey as they shared their experiences. When the journey, or that stage of the journey through life, was over, the things we had found out along the way were gathered up. It was my task to unravel those experiences, being careful not to lose the stories, the veterans' perspectives of what it had meant to travel that route. This gathering up and sorting was captured in Chapter 5 and Chapter 6.

The study built on earlier research I completed for an M.Phil. (Winn, 1998). Exploring with veterans ways to move forward and to share that knowledge with others, for the benefit of the wider veteran community, led me to this research. The veterans who have so generously participated and shared their experiences and thoughts were also motivated by this wish.

My experience as a clinician who has worked with combat veterans for many years is very different from that of a researcher studying a group of combat veterans for the first time and with possibly no clinical experience. A factor not always taken into account is the level of experience and supervision that the dramatherapist has in working with these methods and a particular client group and/or culture (Gersie 1991; Winn, 1994; Lahad, 2000; P. Jones and Dokter, 2008). Whichever therapy is used, mutual respect is necessary and this is emphasised by Johnson (2000) and Landy (2008). The veterans that I work with are at the severe end of the complex trauma polarity; the therapy is time-limited and I work as a lone therapist. These factors were considered in my choice of assessment and treatment model. Gender, culture, environment and therapist training might have influenced my decisions. Wilson (2008) explains the impact of the institutional military culture and how it has defined the soldier's role through history. Dokter (2008) refers to the importance of cultural sensitivity: *'Blindness to one's own and the clients' cultural background, visible or invisible, can lead to dissonance expressed in the peer relationship resulting in scapegoating and drop out'* (p.233). Although Dokter was not writing about military culture, this applies to widely held views and experiences of veterans who have received assessment or treatment from a 'civilian' (Iversen et al., 2011).

It is important that I acknowledge my preconceptions and potential bias due to cultural influences. The research participants each independently stated during the recruitment phase that my clinical background meant I was trustworthy in their veterans' minds. This may have allowed the work to progress in a different and deeper way than for someone coming from a different research background. There was a danger though, that their perceptions of me, might have caused assumptions, leading to shortened explanations of their thoughts and feelings, and the halo effect, referred to in Chapters 1.9 and 3.3. The difficulty is that I might jump to conclusions, based on my fore-understanding (Hefferon and Gil-Rodriguez, 2015). However, using IPA allowed me to consciously step back from my pre-conceptions and deconstruct assumptions. The insights reshaped my previously held knowledge (Macran, Ross and Hardy, 1999). The veterans were keen that their thoughts, feelings and responses were captured within the research. In my view, these veterans have too often not been given the voice to express what works for them. IPA meticulously recorded and examined the veterans' voices. Osborne (1994) reminds researchers that phenomenological research '*emphasises descriptions of meaning of lived description. Opinions are not considered to be lived experience.*' He adds that '*this distinction is crucial during data analysis*' (p.186). This proved a challenge during my research. I find it useful as a practitioner to hear the opinions of those I seek to help. Indeed, I consider their opinions to serve as vital feedback.

It was an onerous, tiring task; it took me some time to realise that the effect of listening to the therapy transcripts over many times during the IPA process was akin to undertaking therapy sessions. One reflection was that I should have better rehearsed my research muscles in preparation for the journey. The research methods would suddenly bear fruit as the phenomena were glimpsed. I was reminded of Smith's assertion '*We could be diving for pearls...*' (2011). Of course not only do pearls need a bit of grit and many years to form in the oyster, the action of diving can be difficult if not precarious. The support through supervision and the IPA forums provided sustenance. The veterans/study participants now offered support to me in the research journey. When I was explaining the length of time the research was taking, Jack's comment was that *it was important that the academics saw the working out.*

In their paper, Chenail and Maione (1997) discuss other challenges facing the clinician researcher:

... researching clinicians must face their previous constructions (i.e., sense-making from experience), create methods, which allow for deconstruction (i.e., sense-making challenged), and then work towards building reconstructions (i.e., sense-making remade) (p.1).

They draw attention to the fact that, depending on their content, the findings of the research can build or shake the confidence of the clinician/researcher. They promote the use of a Y-model for the clinician/researcher (Figure 7.1).

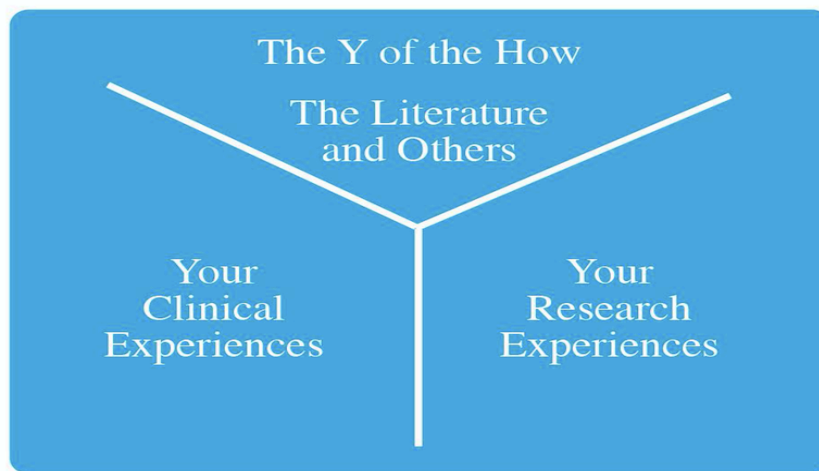


Figure 7.1 Y-model for clinician/researcher (Chenail and Maione, 1997, p.2)

It is suggested that the application of this model is reflected upon regularly during the research, rather than towards the end. This enables the researcher to review and amend their approach if necessary, if the findings are not in keeping with the expected effect. This is of ethical importance; as a clinician, if I were applying a practice that I discovered to be potentially detrimental to a person, I would need to review and amend my practice. When working as a practitioner/researcher I am still bound by these ethics, both professionally and morally.

In addition to the academic supervision supplied during my research, clinical supervision provided an important space to reflect on clinical process with my supervisor. She does not work with veterans, but she is a very experienced dramatherapist, supervisor and academic. I found it useful to have someone that does not work with the same client group. It meant she was able to ask questions, which provoked insights I could have

missed because of my familiarity with the work. Clinical supervision also assists in reducing the risk of burnout, which is a risk when working with trauma

Similarly to phenomenological research the practice of dramatherapy aids the deconstruction of previously held ideas and aids reconstruction to suit the situation that is presented in the here and now. Working with clients involves exploring the ‘What ifs?’ entering the therapeutic space with an enquiring mind; wanting to find out from the participant(s) how it feels to be in their shoes. The dramatherapist knows that ‘one-size’ does not fit all. Of course, that is not to say that training, skills and experience are discarded. Creativity, listening, empathy, and putting yourself in another’s shoes, ensures that these materials are tailored to suit the individual (reconstruction).

I had to be aware of the risk that my familiarity with and acceptance by the veterans as we journeyed through the research process might blind me to the findings or that we might enter into a form of ‘shorthand’ – causing me to pre-empt responses. This would not be so likely to occur with a researcher unfamiliar with the client group, acting as an observer of the process. My counter-argument is that my professional background had given me the privilege of working together with Alan, Chris and Jack to gain an in-depth examination of their experience of dramatherapy. The mixed methods approach had the benefit of triangulation of the results, which also protected against bias. This way of working is close to the dramatherapy protocol that I use in dramatherapy sessions with veterans. The exceptions were the repetition of the SWEMWBS, which would only be used at the start of therapy and the final session and the recorded reflections of the veterans following each session. Normally I would reflect on what takes place; this is not so rigorous nor a line-by-line examination and interpretation as occurs with IPA.

This research process has heightened my respect and sensitivity to the journey of the veteran. It is a journey we undertook together; at times, even when we were not moving from our chairs, it felt like a dance. Sometimes I took the lead, at others I was led and at times it was a dance of equals. I was unsure that I would have been so open to this perception earlier in my career. Times change, the context has changed, from the early 1970s when mental health care in the UK often involved a skewed power balance and lack of acknowledgement that ‘we are all in this together’. I have gained different professional and life experiences. I am older, so do not experience concern in terms of gender differences. I am also not seen in the same way by clients. I was reminded of this, when a young veteran voiced that he wished I could be his mother. Setting aside the discussion of transference, it was a concrete example of shifting discernments. If I was younger I may

have felt differently; instead age frees me to work unencumbered by earlier life concerns. This freedom allows hope as I journey forward through life with my fellow travellers.

7.8 The end of the journey ...

I have not claimed that these results can be generalised to the whole UK veteran community who have PTS. It is argued that generalisability cannot be fully achieved in social science (Eisenhart, 2006; Back, 2002). To answer my questions and address the gap in literature, I needed to examine the detail in the particular and plumb the depths for meaning (J.A. Smith, 2011; Shinebourne and Smith, 2010). The idiographic nature of IPA enabled this. The case study acknowledges the unpredictability of the social world, which was reflected in the impact of the murder of Fusilier Lee Rigby on the quantitative data. Thomas emphasises the importance of the '*exemplary knowledge of abduction and phronesis*' (Thomas, 2010, p.215). The meanings drawn from this research are in the context of my phronesis (the wisdom of practical things). Readers will interpret this study based on their own experiences and horizons of understandings (Widdershoven, 2000). From this they will decide which parts of my contribution to knowledge they recognise or want to study further. The multiple methods synthesis has raised questions and given new insights into the perspectives of veterans participating in dramatherapy compared to results recorded in universal quantitative measures.

I echo Chris when he commented at the end of his TMOC – *this is just the starting point for all of us* The study collected much data not included in the thesis. The results and discussion were shaped by the quest to answer the research questions. I assert that the research has addressed the gap in literature identified in Chapter 1 and the review of literature in Chapter 2. But there is much more to be discovered on the use of dramatherapy in the treatment of PTS.

References

Adrian, E.D., and Yealland, L.R., 1917. The treatment of some common war neuroses. *The Lancet*, 189(4893), pp.867–872.

Aldridge, D., 2005. *Case study designs in music therapy*. London: Jessica Kingsley.

American Psychiatric Association, 1980. *Diagnostic and statistical manual of mental disorders*, 3rd ed. (DSM-III). Washington, DC: American Psychiatric Association.

American Psychiatric Association, 2000. *Diagnostic and statistical manual of mental disorders: DSM-IV-TR*. Washington, DC: American Psychiatric Association.

American Psychiatric Association, 2013. *Diagnostic and statistical manual of mental disorders: DSM-V*. Washington, DC: American Psychiatric Association.

Armitage, S., 2010. *Homer's Odyssey*. Faber and Faber.

Armstrong, K., Best, S. and Domenici, P., 2009. *Courage after fire: Coping strategies for troops returning from Iraq and Afghanistan and their families*. Ulysses Press.

Austin, S.F., 1917. *Principles of drama-therapy* [online]. Available at: <<http://hdl.handle.net/2027/uc2.ark:/13960/t2d796j6f>> [Accessed 28 April 2016].

Back, S., 2002. The Aristotelian challenge to teacher education. *History of Intellectual Culture*, 2(1), pp.1–5.

BADth website (www.badth.org.uk/dtherapy) [Accessed 25 July 2016].

Barbour, V., Clark, J., Peiperl, L., Veitch, E. and Yamey, G., 2009. Media portrayals of suicide. *PloS medicine*, 6(3), p.e51. doi:10.1371/journal.pmed.1000051

- Barglow, P., 2013. We can't treat soldiers' PTSD without a better diagnosis. *Skeptical Inquirer* 36(3), pp.46–49.
- Barker, P., 1993. *The Eye in the Door*. London: Viking.
- Barkham, M., Bewick, B. and Mullin, T., 2013. The CORE-10: a short measure of psychological distress for routine use in the psychological therapies. *Counselling and Psychotherapy Research*, 13(1), pp.3–13.
- Barkham, M., Margison, F., Leach, C., Lucock, M., Mellor-Clark, J., Evans, C., Benson, L., Connell, J., Audin, K., and McGrath, G., 2001. Service profiling and outcomes benchmarking using the CORE-OM: toward practice-based evidence in the psychological therapies. Clinical outcomes in routine evaluation-outcome measures. *Journal of Consulting and Clinical Psychology*, 69, pp.184–196.
- Barkham, M., Stiles, W.B., Connell, J. and Mellor-Clark, J., 2011. Psychological treatment outcomes in routine NHS services: what do we mean by treatment effectiveness? *Psychology and Psychotherapy: Theory, Research and Practice*, 85(1), pp.1–23. doi:10.1111/j.2044-8341.2011.02019.x
- Bartram, D.J., Sinclair, J.M. and Baldwin, D.S., 2013. Further validation of the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) in the UK veterinary profession: Rasch analysis. *Quality of Life Research*, 22, pp.379–391.
- Bar-Yitzhak, R., 2010. Stillborn to reborn: a dramatherapy journey from post trauma to recovery. Ph.D thesis, Anglia Ruskin University.
- Baum, R., Transgenerational trauma and repetition in the body: the groove of the wound. *Body, Movement and Dance in Psychotherapy*, 8(1), pp.34–42.
- Becker, H., 1998. *Tricks of the trade: how to think about research while doing it*. Chicago: University of Chicago Press.
- Bensimon, M., Amir, D. and Wolf, Y., 2008. Drumming through trauma: music therapy with post-traumatic soldiers. *The Arts in Psychotherapy*, 35(1), pp.34–48.
- Bergman, B., Mackay, D. and Pell, J., 2014. Long-term consequences of alcohol misuse in

Scottish military veterans. *Occupational and Environmental Medicine*, 72(1), p.28.

Berntsen, D., Johannessen, K.B., Thomsen, Y.D., Bertelsen, M., Hoyle, R.H. and Rubin, D.C., 2012. Peace and war: trajectories of posttraumatic stress disorder symptoms before, during and after military deployment in Afghanistan. *Psychological science*, 23(12), pp.1557–1565.

Bettelheim, B., 1976. *The use of enchantment*. New York: Knopf.

Biggerstaff, D. and Thompson, A.R., 2008. Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative Research in Psychology*, 5(3), pp.214–224.

Black, D.W., Carney, C.P., Peloso, P.M., Woolson, R.F., Schwartz, D.A., Voelker, M.D., Barrett, D.H. and Doebbeling, B.N., 2004. *Gulf War veterans with anxiety: prevalence, comorbidity and risk factors*. *Epidemiology*, 15(2), pp.135–142.

Blacker, J., Watson, A. and Beech, A., 2008. A combined drama based and CBT approach to working with self reported anger aggression. *Criminal Behaviour and Mental Health*, 18, pp.129–137.

Boone, K.N. and Richardson, F.C., 2010. War neurosis: a cultural historical and theoretical inquiry. *Journal of Theoretical and Philosophical Psychology*, 30(2), pp.109–121.

Bovin, M.J., Marx, B.P., Weathers, F.W., Gallagher, M.W., Rodriguez, P., Schnurr, P.P., and Keane, T.M., 2015. Psychometric properties of the PTSD Checklist for Diagnostic and Statistical Manual of Mental Disorders–Fifth Edition (PCL-5) in Veterans. *Psychological Assessment*, n.p. doi:10.1037/pas0000254.

Bramsen, I. and Ploeg, H.V.D., 1999. Fifty years later: the long-term psychological adjustment of ageing World War II survivors. *Acta Psychiatrica Scandinavica*, 100(5), pp.350–358.

Breakwell, G.M., Smith, J.A., and Wright, D.B., 2012. *Research methods in psychology*. 4th ed. London: Sage.

Bremner, J.D., Southwick, S.M., Johnson, D.R., Yehuda, R. and Charney, D.S. 1993. Childhood physical abuse and combat-related posttraumatic stress disorder in Vietnam veterans. *American Journal of Psychiatry*, 150(2):pp.235–239.

British Army, 2014. The British Army – trauma risk management (TriM) [pdf] [online]. Available at:

<<http://www.kcl.ac.uk/kcmhr/publications/assetfiles/screening/Greenberg2008-trim.pdf>> [Accessed 28 April 2016].

Brooker, J., Cullum, M., Gilroy, A., McCombe, B., Mahony, J., Ringrose, K., Russell, D., Smart, L., Zweigbergk, B. von and Waldman, J., 2007. *The use of art work in art psychotherapy with people who are prone to psychotic states: an evidence-based clinical practice guideline* [pdf]. Goldsmiths, University of London [online]. Available at:

<http://research.gold.ac.uk/112/1/PAC-Gilroy2007a_GRO.pdf> [Accessed 28 April 2016].

Browne, T., Hull, L., Horn, O., Jones, M., Murphy, D., Fear, N.T., Greenberg, N., French, C., Rona, R.J., Wessely, S. and Hotopf, M., 2007. Explanations for the increase in mental health problems in UK reserve forces who have served in Iraq. *British Journal of Psychiatry : the Journal of Mental Science*, 190, pp.484–489.

Bryan, C.J., Jennings, K.W., Jobes, D.A. and Bradley, J.C., 2012. Understanding and preventing military suicide. *Archives of Suicide Research*, 16(2), pp.95–110. doi:10.1080/13811118.2012.667321.

Bunt, L. and Stige, B., 2014. *Music Therapy: An art beyond words*. 2nd ed. London: Taylor and Francis.

Buonanno, P., 2007. Long-term effects of conscription: lessons from the UK. University of Bergamo, Department of Economics, Working Paper 0604.

Burton-Fanning, F.W., 1917. Neurasthenia in Soldiers of the Home Forces. *The Lancet*, 189(4894), pp.907–911.

Campbell, D., 1975. ‘Degrees of Freedom’ and the case study. *Comparative Political Studies*, 8(2), pp.178–193.

- Campbell, D. and Stanley, J.C., 1966. *Experimental and quasi-experimental designs for research*. Chicago: Rand McNally.
- Campbell, J., 2008. The hero with a thousand faces (The collected works of Joseph Campbell). *New World Library*.
- Campbell, S. and Scott, J., 2011. Process of conducting qualitative research: Steve Campbell and John Scott describe how this issue's themed papers contribute to the debate on the ethical conduct of qualitative research. *Nurse researcher*, 18(2), pp.4-6.
- Carr, M. and Andersen-Warren, M., 2012. A research interview: dramatherapy and cross-cultural awareness. *Dramatherapy*, 34(2), pp.92–100.
- Cassidy, S., Turnbull, S. and Gumley, A., 2014. Exploring core processes facilitating therapeutic change in Dramatherapy: a grounded theory analysis of published case studies. *The Arts in Psychotherapy*, 41(4), pp.353–365.
- Casson, J., 1997. Dramatherapy history in headlines: who did what, when, where? *Dramatherapy*, 19(2), pp.10–13.
- Casson, J., 1999. Dramatherapy, psychodrama and dreamwork. *Dramatherapy*, 21(1), pp.15–18.
- Casson, J., 2001. *Dramatherapy, psychodrama and voices*. *Dramatherapy*, 23(2), 23–25. doi:10.1080/02630672.2001.9689581
- Casson, J., 2005. The Communicube: further clinical developments of a new therapeutic method. *Dramatherapy*, 27(3), pp.15–18.
- Casson, J., 2014. Scenes from a distance: psychodrama and dramatherapy. In: K. Holmes, P., Farrall, M. and Kirk, ed., *Empowering Therapeutic Practice: Integrating Psychodrama into other Therapies*. London: Jessica Kingsley.
- Chenail, R.J. and Maione, P., 1997. Sensemaking in clinical qualitative research. *The Qualitative Report – an online journal dedicated to qualitative research and critical inquiry*. [online]. Available at: <http://www.nova.edu/ssss/QR/QR3-1/sense.html> [Accessed 29 April 2016].

- Chenail, R.J., 2011. Interviewing the investigator: Strategies for addressing instrumentation and researcher bias concerns in qualitative research. *The Qualitative Report*, 16(1), p.255.
- Chouinard, S. and Ford, B., 2000. Adult onset tic disorders. *Journal of Neurology, Neurosurgery & Psychiatry*, 68(6), pp.738-743.
- Chu, J.A., 2011. *Rebuilding shattered lives: Treating complex PTSD and dissociative disorders*. Chichester: Wiley.
- Clark, D.M., Layard, R., Smithies, R., Richards, D.A., Suckling, R. & Wright, B., 2009. Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy*, 47, 910–920
- Cooper, J., Appleby, L. and Amos, T., 2002. Life events preceding suicide by young people. *Social Psychiatry and Psychiatric Epidemiology*, 37, pp.271–275.
- Core System Group, 1998. *CORE System (Information Management) Handbook*. Leeds: Core System Group.
- Cox, M. and Theilgaard, A., 1994. *Shakespeare as Prompter: The amending imagination and the therapeutic process*. Jessica Kingsley Publishers.
- Cox, M. and Theilgaard, A., 1997. *Mutative metaphors in psychotherapy: The Aeolian mode*. Jessica Kingsley Publishers.
- Craft, A., 2001. Little c creativity. *Creativity in education*, 45.
- Crawford, M.J., Robotham, D., Thana, L., Patterson, S., Weaver, T., Barber, R., Wykes, T. and Rose, D., 2011. Selecting outcome measures in mental health: the views of service users. *Journal of Mental Health*, 20(4), pp.336-346.
- Creswell, J.W., 2011a. Controversies in mixed methods research. In: N.K. Denzin and Y.S. Lincoln, eds, *The Sage handbook of qualitative research*. London: Sage, pp.269–284.
- Creswell, J.W., 2011b. *Designing and conducting mixed methods research*. London: Sage.

Creswell, J.W., 2014. *Research design: qualitative, quantitative, and mixed methods approaches*. 4th ed. London: Sage.

Creswell, J.W. and Piano Clark, J., 2011. *designing and conducting mixed methods research*. 2nd ed. London: Sage.

Dahlberg, K., Dahlberg, H. and Nysstrom, M., 2008. *Reflective lifeworld research*. 2nd ed. Lund, Sweden: Studentlitteratur.

Dandeker, C., Greenberg, N. and Orme, G., 2011. The UK's reserve forces: retrospect and prospect. *Armed Forces & Society*, 37, pp.341–360.

Dandeker, C., Thomas, S., Dolan, M., Chapman, F. and Ross, J., 2005. Feasibility study on the extent, causes, impact and costs of rough sleeping and homelessness amongst ex service personnel in a sample of local authorities in England. [pdf] Available at: <<http://www.kcl.ac.uk/kcmhr/publications/assetfiles/veterans/Dandeker2005-feasabilitystudyhomeless.pdf>> [Accessed 28 April 2016].

Dandeker, C., Wessely, S., Iversen, A. and Ross, J. 2006. What's in a name? Defining and caring for 'veterans': the United Kingdom in international perspective. *Armed Forces & Society*, 32(2), pp.161–177.

Deahl, M.P., Klein, S. and Alexander, D.A., 2011. The costs of conflict: meeting the mental health needs of serving personnel and service veterans. *International Review of Psychiatry*, 23(2), pp.201–209.

Deahl, M. and Siddiquee, R., 2013. What civilian psychiatrists should know about military psychiatry. *Advances in Psychiatric Treatment*, 19(4), pp.268–275.

Debell, F., Fear, N., Head, M., Batt-Rawden, S., Greenberg, N., Wessely, S. and Goodwin, L. 2014. A systematic review of the comorbidity between PTSD and alcohol misuse. *Social Psychiatry and Psychiatric Epidemiology*, 49(9), pp.1401–1425.

Dekel, S. Mandl, C. and Solomon, Z., 2011. Shared and unique predictors of post-traumatic growth and distress. *Journal of Clinical Psychology*, 67(3), pp.241–252.

Dent-Brown, K., 2011. Six-Part Storymaking—a tool for CAT practitioners. *Reformulation*,

36 (Summer), pp.34–36.

Denzin, N., 2012. Triangulation 2.0. *Journal of Mixed Methods Research*, 6(2), pp.80–88.

De Witt, L. and Ploeg, J., 2006. Critical appraisal of rigour in interpretive phenomenological nursing research. *Journal of Advanced Nursing*, 55(2), pp.215–229.

Dokter, D., 2008. Cultural variables affecting client: the perception of efficacy in arts therapies group treatment. Ph.D thesis, University of Hertfordshire.

Dokter, D. and Winn, L., 2009. Evidence based practice, a dramathrapy research project. *Dramathrapy*, 31(1), pp.3–9.

Dokter, D., Holloway, P. and Seebom, H., 2011. *Dramathrapy and destructiveness: Creating the evidence base, playing with Thanatos*. London: Routledge.

Dolan, S., Martindale, S., Robinson, J., Kimbrel, N.A., Meyer, E.C., Kruse, M.I., Morissette, S.B., Young, K.A. and Gulliver, S.B., 2012. Neuropsychological sequelae of PTSD and TBI following war deployment among OEF/OIF veterans. *Neuropsychology Review*, 22(1), pp.21–34.

Doty, W.G., 2000. *Mythography: The study of myths and rituals*. 2nd ed. University of Alabama Press.

Douglass, B.G.B., and Moustakas, C., 1985. Heuristic inquiry: the internal search to know. *Journal of humanistic Psychology*, 25(3), pp.39–55.

Dowling, M., 2007. From Husserl to van Manen: a review of different phenomenological approaches. *International Journal of Nursing Studies*, 44(1), pp.131–142.

Du Preez, J., Sundin, J., Wessely, S. and Fear, N.T., 2012. Unit cohesion and mental health in the UK armed forces. *Occupational medicine*, 62(1), pp.47–53.

Eberhard-Kaechele, M., 2012. Memory, metaphor, and mirroring in movement therapy with trauma patients. In: S.C. Koch, T. Fuchs, M. Summa and C. Müller, eds, *Body Memory, Metaphor and Movement*. Advances in Consciousness Research, 84. Amsterdam, The Netherlands: John Benjamin, pp.267–287.

Edelman, R. and Chambless, D., 1995. Adherence during sessions and homework in cognitive-behavioral group treatment of social phobia. *Behaviour Research and Therapy*, 33(5), pp.573–577.

Ehlers, A., 2010. Understanding and treating unwanted trauma memories in posttraumatic stress disorder. *Zeitschrift fur Psychologie*, 218(2), pp.141–145.

Eisenhart, M., 2006. Representing qualitative data. In: G.L. Green, G. Camilli and P.B. Elmore, *Handbook of complementary methods in education research*. American Educational Research Association. Mahwah, NJ: Erlbaum, pp.567–581.

Ellingson, L.L., 2009. *Engaging crystallization in qualitative research: an introduction*. London: Sage.

Evans, C., 2012. Cautionary notes on power steering for psychotherapy. *Canadian Psychology/Psychologie canadienne*, 53(2), pp.131–139. doi:10.1037/a0027951.

Evans, C. 2013. *The danger of trading measures but not meeting distressed minds: 'outcome' measurement in MH and psychological therapies* [online]. Available at: http://www.psych.org/talks/2013/20130417_RCPsych_Faculty_talk.pdf [Accessed 8 July 2016].

Faulks, S., 1993. *Birdsong*. London: Hutchinson.

Fear, N.T., Jones, M., Murphy, D., Hull, L., Iversen, A.C., Coker, B., Machell, L., Sundin, J., Woodhead, C. and Jones, N., 2010. What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. *The Lancet*, 375(9728), pp.1783–1797.

Finlay, L., 2011. *Phenomenology for Therapists: Researching the Lived World*. Oxford: Wiley-Blackwell.

Finlay, L., 2014. Engaging phenomenological analysis. *Qualitative Research in Psychology*, 11(2), pp.121–141.

Fisher, J., 2000. Adapting EMDR techniques in the treatment of dysregulated or dissociative patients. Paper presented at the Annual Meeting of the International Society

for the Study of Association [pdf]. Available at: <<http://janinafisher.com/pdfs/emdr.pdf>> [Accessed 1 Oct. 2014].

Fisher, M.P. and Schell, T.L., 2013. *The role and importance of the D in PTSD*. RAND National Defense Research Inst. Santa Monica Ca.

Flyvbjerg, B., 2006. Five misunderstandings about case-study research. *Qualitative Inquiry*, 12(2), p.219–245. doi:10.1177/1077800405284363

Foa, E., Gillihan, S.J. and Bryant, R.A., 2013. Challenges and successes in dissemination of evidence-based treatments for posttraumatic stress: Lessons learned from prolonged exposure therapy for PTSD. *Psychological Science in the Public Interest*, 14(2), pp.65–111.

Foa, E., Keane, T.M, Friedman, M.J. and Cohen, J., 2009. *Effective treatments for PTSD: practice guidelines from the International Society for Traumatic Stress Studies*. 2nd ed. London: Guilford Press.

Ford, J.D., 1999. Disorders of extreme stress following war-zone military trauma: Associated features of posttraumatic stress disorder or comorbid but distinct syndromes? *Journal of Consulting and Clinical Psychology*, 67(1), pp.3–12.

Forgas, J.P., 2011. She just doesn't look like a philosopher...? Affective influences on the halo effect in impression formation. *European Journal of Social Psychology*, 41(7), pp.812–817.

Fossey, M., 2010. *Veterans, mental health and vulnerability*. London: Centre for Mental Health.

Fossey, M., 2012. *Developing a better understanding of the emotional support needs of service families*. London: Centre for Mental Health.

Frappell-Cooke, W., Gulina, M., Green, K., Hacker Hughes, J. and Greenberg, N., 2010. Does trauma risk management reduce psychological distress in deployed troops? *Occupational Medicine*, 60, pp.645–650.

French, C., Rona, R.J., Jones, M. and Wessely, S., 2004. Screening for physical and

psychological illness in the British Armed Forces: II: barriers to screening--learning from the opinions of Service personnel. *Journal of Medical Screening*, 11, pp.153–157.

Gerger, H., Munder, T. and Barth, J., 2013. Specific and nonspecific psychological interventions for PTSD symptoms: a meta-analysis with problem complexity as a moderator. *Journal of Clinical Psychology*, 70(7), pp.601–615.

Gersie, A., 1991. *Storymaking in bereavement: dragons fight in the meadow*. London: Jessica Kingsley.

Gersie, A., 1996. *Dramatic approaches to brief therapy*. London: Jessica Kingsley.

Gersie, A., and King, N., 1990. *Storymaking in education and therapy*. London: Jessica Kingsley.

Giebel, C.M., Clarkson, P. and Challis, D., 2014. Demographic and clinical characteristics of UK military veterans attending a psychological therapies service. *Psychiatric Bulletin*, 38, 270—275.

Gill, B., Meltzer, H., Hinds, K. and Petticrew, M., 1996. OPCS surveys of psychiatric morbidity in Great Britain, report 7: psychiatric morbidity among homeless people. London: OPCS.

Gilroy, A., 2006. *Art therapy, research and evidence-based practice*. London: Sage.

Githaiga, J. N., 2104. Methodological considerations in utilization of focus groups in an IPA study of bereaved parental cancer caregivers in Nairobi. *Qualitative Research in Psychology*, 11(4), pp.400–419.

Goodwin, L. and Rona, R.J., 2013. PTSD in the armed forces: what have we learned from the recent cohort studies of Iraq/Afghanistan? *Journal of Mental Health* 22(5), pp.397–401.

Grainger, R., 1999. *Researching the Arts Therapies: A Dramatherapist's Perspective*. London: Jessica Kingsley.

Grainger, R. 2010. *Suspending disbelief: theatre as context for sharing*. Eastbourne, UK: Sussex Academic Press.

Greenberg, N., Langston, V. and Jones, N., 2008. Trauma risk management (TriM) in the UK Armed Forces. *Journal of the Royal Army Medical Corps*, 154(2), pp.124–127.

Greenberg, N., Jones, E., Jones, N., Fear, N.T. and Wessely, S., 2011a. The injured mind in the UK Armed Forces. *Philosophical Transactions of the Royal Society of London. Series B, Biological sciences*, 366(1562), pp.261–267.

Greenberg, N., Langston, V., Iversen, A. and Wessely, S., 2011b. The acceptability of ‘Trauma Risk Management’ within the UK Armed Forces. *Occupational medicine*, 61(3), pp.184–189.

Greene, J. C. and Caracelli, V. J. 2003. Making paradigmatic sense of mixed methods practice. In A. Tashakkori and C. Teddlie, eds., *Handbook of mixed methods in social and behavioral research*. Thousand Oaks, CA: Sage, pp.91–110.

Guba, E.G. and Lincoln, Y.S., 1989. Fourth generation evaluation. *New Bury Park: CA: Sage*.

Guion, L., Diehl, D., and McDonald, D., 2011. Triangulation: establishing the validity of qualitative studies. University of Florida: IFAS Extension.

Gunnell, D., Bennewith, O., Simkin, S., Cooper, J., Klineberg, E., Rodway, C., Sutton, L., Steeg, S., Wells, C., Hawton, K. and Kapur, N., 2012. Time trends in coroners’ use of different verdicts for possible suicides and their impact on officially reported incidence of suicide in England: 1990–2005. *Psychological Medicine*, 43(7), pp.1415–1422. doi: 10

Habermas, J. and Levin, T.Y., 1982. The entwinement of myth and enlightenment: Re-reading dialectic of enlightenment. *New German Critique*, (26), pp.13-30.
doi: 10.2307/488023

Harper D., 2012. Choosing a qualitative research method. In: Harper D. and Thompson A. eds., *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students*: Wiley, Chichester, pp. 83–97.

Harris, D.A., 2009. The paradox of expressing speechless terror: Ritual liminality in the creative arts therapies' treatment of posttraumatic distress. *The Arts in Psychotherapy*, 36(2), pp.94-104.

Harvey, S.B., Hatch, S.L., Jones, M., Hull, L., Jones, N., Greenberg, N., Dandeker, C., Fear, N.T. and Wessely, S., 2011. Coming home: social functioning and the mental health of UK reservists on return from deployment to Iraq or Afghanistan. *Annals of Epidemiology*, 21, pp.666–672.

Hatch, S.L., Harvey, S.B, Dandeker, C., Burdett, H., Greenberg, N., Fear, N.T. and Wessely, S., 2013. Life in and after the Armed Forces: social networks and mental health in the UK military. *Sociology of Health and Illness*, 35(7), 1045–1064. doi: 10.1111/1467-9566.12022

Health and Care Professions Council,(HCPC) 2013. *Standards of Proficiency for Arts Therapists*. [online]. Available at: <www.hpc-uk.org> [Accessed 28 April 2016].

Health and Social Care Information Centre, 2013. Mental health minimum data set linked to hospital episode statistics. *Health* [online]. Available at: <<http://www.hscic.gov.uk/article/2740/Mental-Health-Minimum-Data-Set-Linked-to-Hospital-Episode-Statistics>> [Accessed 28 April 2016].

Health and Social Care Information Centre. 2014. *Routine Quarterly MHMDS Reports* [online]. Available at: <<http://www.hscic.gov.uk/article/2290>> [Accessed 6 Oct. 2014].

Hefferon, K., and Gil-Rodriguez, E., 2011. Interpretative phenomenological analysis. *Psychologist*, 24(10), pp.756–759.

Hefferon, K., and Gil-Rodriguez, E., 2015. In: *London IPA Training Manual*. London: the authors, p.80.

Hefferon, K., Greal, M., and Mutrie, N. (2010). Transforming from cocoon to butterfly: the potential role of the body in the process of posttraumatic growth. *Journal of Humanistic Psychology*, 50(2), pp.224–247.

- Heidegger, M., 1962 [1927]. *Being and Time*. Translated from German by J. MacQuarrie and E. Robinson. Oxford: Blackwell.
- Herman, J.L., 1992. *Trauma and recovery*. New York: Basic Books.
- Heron, J., 1996. *Co-operative inquiry: Research into the human condition*. London: Sage.
- Heron, J. and Reason, P., 1997. A participatory inquiry paradigm. *Qualitative inquiry*, 3(3), pp.274-294.
- Heron, J., 2001a. *Helping the client: A creative practical guide*. Sage.
- Heron, J., 2001b. Transpersonal co-operative inquiry. *Handbook of action research: Participative inquiry and practice*, pp.333-339.
- Hesse-Biber, S.N., 2010. *Mixed methods research: merging theory with practice*. London: Guilford Press.
- Hickman, T., 2004. *The call up*. London: Headline.
- Hiles, D., 2002. Narrative and heuristic approaches to transpersonal research and practice. Paper presented to CCPE, London [online]. Available at: <<http://psy.dmu.ac.uk/drhiles/N&Hpaper.htm>> [Accessed 29 April 2016].
- Hill, A., 1945. *Art versus illness, a story of art therapy*. London: Allen and Unwin.
- Hinds, J., 2011. Exploring the psychological rewards of a wilderness experience: an interpretive phenomenological analysis. *Humanistic Psychologist*, 39(3), pp.189–205.
- Hogan, S., 2001. *Healing arts: the history of art therapy*. London: Jessica Kingsley.
- Hogberg, G., Nardo, D., Hallstrom, T. and Pagani, M., 2011. Affective psychotherapy in post-traumatic reactions guided by affective neuroscience: memory reconsolidation and play. *Psychology Research and Behavior Management*, 4, pp.87–96.
- Hoge, C.W., Castro, C.A., Messer, S.C., 2004. Combat duty in Iraq and Afghanistan, mental health problems and barriers to care. *New England Journal of Medicine*, 351, pp.13–22 .

- Holmes, J., Fear, N.T., Harrison, K., Sharpley, J. and Wessely, S., 2013. Suicide among Falkland war veterans. *British Medical Journal*, 346, p.3204.
- Hotopf, M., Hull, L., Fear, N.T., Browne, T., Horn, O., Iversen, A., Jones, M., Murphy, D., Bland, D. and Earnshaw, M., 2006. The health of UK military personnel who deployed to the 2003 Iraq war: a cohort study. *The Lancet*, 367(9524), pp.1731–1741.
- Hughes, J.H., Cameron, F., Eldridge, R., Devon, M., Wessely, S. and Greenberg, N., 2005. Going to war does not have to hurt: preliminary findings from the British deployment to Iraq. *British Journal of Psychiatry: the Journal of Mental Science*, 186(6), pp.536–7.
- Hunt, E.J.F., Wessely, S., Jones, N., Rona, R.J. and Greenberg, N., 2014. The mental health of the UK Armed Forces: where facts meet fiction. *European Journal of Psychotraumatology*, 5. doi: 10.3402/ejpt.v5.23617
- Husserl, E., 1999 [1907]. *The idea of phenomenology*. Translated from German by L. Hardy. Guildford: Springer.
- IAPT. (2011). The IAPT Data Handbook Guidance on recording and monitoring outcomes to support local evidence-based practice. Version 2. March 2011. London, Available at: <<http://webarchive.nationalarchives.gov.uk/20160302154833/http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-v2.pdf>> [accessed 28 August 2016].
- Insel, TR 2010, 'FAULTY CIRCUITS', *Scientific American*, 302, 4, pp. 44-51.
- Iversen, A.C. and Greenberg, N., 2009. Mental health of regular and reserve military veterans . *Advances in Psychiatric Treatment*, 15(2), pp.100–106.
- Available at: <<http://www.macrothink.org/journal/index.php/ijsw/article/view/5289>> [Accessed 28 April 2016]. doi:10.5296/ijsw.v1i1.528
- Iversen, A., Dyson, C. and Smith, N., 2005. 'Goodbye and good luck': the mental health needs and treatment experiences of British ex-service personnel. *British Journal of Psychiatry*, 186(June), pp.480–486.
- Iversen, A., Nikolaou, V., Greenberg, N., Unwin, C., Hull, L., Hotopf, M., Dandeker, C., Ross, J. and Wessely, S., 2005. What happens to British veterans when they leave the armed forces? . *European Journal of Public Health*, 15(2), pp.175–184.

Iversen, A.C., Fear, N.T., Ehlers, A., Hacker Hughes, J., Hull, L., Earnshaw, M., Greenberg, N., Rona, R., Wessely, S. and Hotopf, M., 2008. Risk factors for post-traumatic stress disorder among UK Armed Forces personnel. *Psychological Medicine*, 38(4), pp.511–22.

Iversen, A.C., van Staden, L., Hughes, J.H., Browne, T., Hull, L., Hall, J., Greenberg, N., Rona, R.J., Hotopf, M., Wessely, S. and Fear, N.T., 2009. The prevalence of common mental disorders and PTSD in the UK military: using data from a clinical interview-based study. *BMC Psychiatry*, 9(1), p.68. doi: 10.1186/1471-244X-9-68

Iversen, A.C., van Staden, L., Hughes, J.H., Browne, T., Greenberg, N., Hotopf, M., Rona, R.J., Wessely, S., Thornicroft, G. and Fear, N.T., 2010. Help-seeking and receipt of treatment among UK service personnel. *British Journal of Psychiatry : the Journal of Mental Science*, 197(2), pp.149–55.

Iversen, A.C., van Staden, L., Hughes, J.H., Greenberg, N., Hotopf, M., Rona, R.J., Thornicroft, G., Wessely, S. and Fear, N.T., 2011. The stigma of mental health problems and other barriers to care in the UK Armed Forces. *BMC Health Services Research*, 11(1), p.31.

Jakupcak, M., Tull, M. and McDermott, M., 2010. PTSD symptom clusters in relationship to alcohol misuse among Iraq and Afghanistan war veterans seeking post-deployment VA health care. *Addictive Behaviors*, 35(9), pp.840–843.

James, M., Johnson, D.R., Rosenheck, R., Fontana, A. and Lubin, H., 1996. Drama therapy in the treatment of combat-related post-traumatic stress disorder. *The Arts in Psychotherapy*, 23(5), pp.383–395.

Jenkins, R., Meltzer, H., Bebbington, P., Brugha, T., Farrell, M., McManus, S. and Singleton, N., 2009. The British Mental Health Survey Programme: achievements and latest findings. *Social Psychiatry and Psychiatric Epidemiology*, 44, pp.899–904.

Jenkyns, M., 1996. *The play's the thing*. London: Jessica Kingsley.

Jenkyns, M., 1999. Not with bag and baggage but with scrip and scrippage. *Dramatherapy*, 21(1), pp.10–14.

Jennings, S., 1992. *Dramatherapy with families, groups, and individuals: waiting in the wings*. London: Jessica Kingsley.

Jennings, S., 2004. 'It's hard to make roots': dramatherapy, playtherapy and creative theatre. In International Organization for Migration, *Psychosocial Notebook, Volume 4: psychosocial support to groups of victims of human trafficking in transit situations*, pp.43–58.

Jennings, S., 2010. *Creative drama in groupwork*. 2nd ed. Milton Keynes, UK: Speechmark.

Jennings, S., 2012. Drama Therapy Assessment through Embodiment-Projection-Role. In: Johnson, D.R., Pendzik, S. and Snow, S., eds, *Assessment in drama therapy*. Springfield, IL: Charles Thomas, pp. 177-196.

Jennings, S., 2016. EPR with adults. Personal communication [e-mail 5.4.16].

Jennings, S., Cattanach, A., Mitchell, S., Chesner, A., Meldrum, B. and Nfa, S.M., eds, 2005. *The handbook of dramatherapy*. London: Routledge.

Johnson, D.R., 1987. The role of the creative arts therapies in the diagnosis and treatment of psychological trauma. *The Arts in Psychotherapy*, 14, pp.7–13.

Johnson, D.R., 1990. The drama therapist “in role” in: Jennings, S. ed., *Dramatherapy: Theory and practice*. Vol. 2, London: Routledge, pp.131-132.

Johnson, D.R., 2000. *Developmental transformations: towards the body as presence. Current approaches in drama therapy*. Springfield, IL: Charles C Thomas.

Johnson, D.R., 2009a. Commentary: examining underlying paradigms in the creative arts therapies of trauma. *The Arts in Psychotherapy*, 36(2), pp.114–120.

Johnson, D.R., 2009b. Developmental transformations: Towards the body as presence. *Current approaches in drama therapy*, 2, pp.65-88.

Johnson, D.R., 2010a. *Healing trauma through the arts*. Philadelphia: Temple University.

- Johnson, D.R, 2010b. Performing absence: the limits of testimony in the recovery of the combat veteran.' In: E. Leveton, ed., *Healing collective trauma using sociodrama and dramatherapy*. New York: Springer, pp.55–80.
- Johnson, D.R, and Emunah, R., 2009. *Current approaches in drama therapy*. Springer, IL: Charles C. Thomas.
- Johnson, D.R. and Feldman, S., 1995. The therapeutic use of ritual and ceremony in the treatment of post-traumatic stress disorder. *Journal of Traumatic Stress*, 8(2), pp.283–298.
- Johnson, D.R., Lahad, M. and Gray, A. 2009. Creative therapies for adults in Foa, E., Keane, T.M, Friedman, M.J. and Cohen, J. *Effective treatments for PTSD: practice guidelines from the International Society for Traumatic Stress Studies*. 2nd ed. London: Guilford Press, p.p. 479-490
- Johnson, D.R and Lubin, H., 1997. Treatment preferences of Vietnam veterans with posttraumatic stress disorder. *Journal of Traumatic Stress*, 10(3), pp 391–405.
- Johnson, D.R., Rosenheck, R., Fontana, A. Lubin, H. and Southwick, S. 1996. Outcome of intensive inpatient treatment for combat-related posttraumatic stress disorder. *American Journal of Psychiatry*, 153(6), 771–777.
- Johnson, D.R., Fontana, A., Lubin, H., Corn, B. and Rosenheck, R., 2004. Long-term course of treatment-seeking Vietnam veterans with posttraumatic stress disorder: mortality, clinical condition, and life satisfaction. *Journal of Nervous and Mental Disease*, 192(1), pp.35–41.
- Johnson, D.R., 2011. Diagnostic Role-Playing Test. In: Johnson, D.R., Pendzik, S. and Snow, S., eds, *Assessment in drama therapy*. Springfield, IL: Charles Thomas, pp. 61-90.
- Jones, E. and Wessely, S., 2005a. *Shell shock to PTSD: military psychiatry from 1900 to the Gulf War*. Oxford: Psychology Press.
- Jones, E. and Wessely, S., 2005b. War Syndromes: The Impact of Culture on Medically Unexplained Symptoms. *Medical History*, 49(1), pp.55–78.
- Jones, E., Hodgins-Vermaas, R., McCartney, H., Everitt, B., Beech, C., Poynter, D.,

Palmer, I., Hyams, K. and Wessely, S., 2002. Post-combat syndromes from the Boer war to the Gulf war: a cluster analysis of their nature and attribution. *British Medical Journal (Clinical Research)*, 324, pp.321–324.

Jones, M., Fear, N.T., Greenberg, N., Jones, N., Hull, L., Hotopf, M., Wessely, S. and Rona, R.J., 2008. Do medical services personnel who deployed to the Iraq war have worse mental health than other deployed personnel? *European Journal of Public Health*, 18(4), pp.422–7.

Jones, N., Wink, P., Brown, R.A., Berreclough, D., Abson, E., Doyle, J., Fear, N.T., Wessely, S. and Greenberg, N., 2011. A clinical follow-up study of reserve forces personnel treated for mental health problems following demobilisation. *Journal of Mental Health*, 20, pp.136–145.

Jones, P., 1996. *Drama as therapy: theatre as living*. London: Routledge.

Jones, P., 2005. *The arts therapies: a revolution in healthcare*. Oxford: Psychology Press.

Jones, P., 2007. *Drama as therapy, volume 1: theory, practice and research*. (2nd edition). London: Routledge.

Jones, P., 2008. Research into the core processes of drama therapy: vignettes and conversations. *The Arts in Psychotherapy*, 35(4), pp.271–279.

Jones, P., 2012. Approaches to the futures of research (Based on the conference keynote, British Association of Dramatherapists Conference 2011, Measure for measures, researching, re-viewing and re-framing dramatherapy in practice). *Dramatherapy*, 34(2), pp.63–82. doi:10.1080/02630672.2012.704189

Jones, P., 2013. An analysis of the first articulation of drama therapy: Austin's 'Principles of drama-therapy: a handbook for dramatists' (1917). *Arts in Psychotherapy*, 40(3), pp.352–357.

Jones, P. and Dokter, D., 2008. *Supervision of dramatherapy: supervision in the arts therapies*. London: Routledge.

Joseph, S., Murphy, D. and Regel, S. 2012. An affective–cognitive processing model of

post-traumatic growth. *Clinical Psychology and Therapy*, Special Issue, 19(4), pp.316–325.

Kapur, N., While, D., Blatchley, N., Bray, I. and Harrison, K., 2009. Suicide after leaving the UK armed forces – a cohort study, ed. M. Hotopf. *PloS medicine*, 6(3), p.e26.
doi:10.1371/journal.pmed.1000026

Karkou, V., 2012. *Aspects of theory and practice in dance movement psychotherapy in the UK: similarities and differences from music therapy*. In: R MacDonald, G. Kreutz and L. Mitchell (eds), *Music, health and wellbeing*. Oxford: Oxford University Press, pp.213–229.

Karkou, V., 2010. *Arts therapies in schools: Research and practice*. Jessica Kingsley Publishers.

Karkou, V. and Sanderson, P., 2006. *Arts therapies: a research-based map of the field*. Edinburgh: Elsevier.

Kessler, R.C., Chiu, W.T., Demler, O., Merikangas, K.R. and Walters, E.E., 2005. Prevalence, severity and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), pp.617–627.

Kinowski, K., 2003. Put your best foot forward: an EDMR-related protocol for empowerment using somatosensory and visual priming of resource experiences. Victoria, BC: the author [online]. Available from:
<<http://www.krystynakinowski.com/downloads.html>>.

Kirkham, J.A., Smith, J.A. and Havsteen-Franklin, D., 2015. Painting pain: an interpretative phenomenological analysis of representations of living with chronic pain. *Health Psychology*, 34(4), p.398.

Koch, A.S. and Forgas, J.P., 2012. Feeling good and feeling truth: The interactive effects of mood and processing fluency on truth judgments. *Journal of Experimental Social Psychology*, 48(2), pp.481-485.

Kuhn, T.S. (1987). What are scientific revolutions? In: Kruger, L., Daston, L.J. and

Heidelberger, M. eds.. *The probabilistic revolution, Vol. 1: Ideas in history*. Cambridge, MA: MIT Press, pp. 7-22.

Lahad, M., 1992. Storymaking in assessment method for coping with stress: six-piece storymaking and BASIC Ph. In: Jennings, S., ed., *Dramatherapy: theory and practice*. Vol 2. London: Routledge, pp.150–163.

Lahad, M., 1995. Masking the gas mask: brief intervention using metaphor, imagery, movement and enactment. In: A. Gersie, ed., *Dramatic approaches to brief therapy*. London: Jessica Kingsley, pp.139–145.

Lahad, M., 2000. *Creative supervision: the use of expressive arts methods in supervision and self-supervision*. London: Jessica Kingsley.

Lahad, M. and Cohen, A. eds., 1988. *Community stress prevention*. Kiriat Shmona, Israel: Community Stress Prevention Centre.

Lahad, M. and Doron, M., 2010. *Protocol for treatment of post traumatic stress disorder: SEE FAR CBT model: beyond cognitive behavior therapy*. Amsterdam, The Netherlands: IOS Press.

Lahad, M. and Dent-Brown, K., 2011. Six-piece storymaking revisited: the seven levels of assessment and the clinical assessment. In: Johnson, D.R., Pendzik, S. and Snow, S., eds, *Assessment in drama therapy*. Springfield, IL: Charles Thomas, pp. 121-147.

Lahad, M., Leykin, D., 2012. The Healing Potential of Imagination in the Treatment of Psychotrauma: An alternative explanation for the effectiveness of the treatment of PTSD using Fantastic Reality. In: Lee, S.A. and Edget, D.M., eds, *Cognitive Behavioral Therapy, Application, Methods and Outcomes*. New York: Nova, pp. 71-93.

Lahad, M., Farhi, M., Leykin, D. and Kaplansky, N., 2010. Preliminary study of a new integrative approach in treating post-traumatic stress disorder: SEE FAR CBT. *The Arts in Psychotherapy*, 37(5), pp.391–399.

Lahad, M., Schacham, M., and Ayalon, O., 2013. *The 'BASIC Ph' model of coping and resiliency: theory, research and cross-cultural application*. London: Jessica Kingsley.

- Lahad, M., Leykin, D., Rozenblat, O. and Fajerman, Z., 2014. Exploring the efficacy of anxiety and PTSD therapeutic techniques and protocols in practice during ongoing terrorism: evidence from a focus group research. *International Journal of Social Work*, 1(1). Available at: <<http://www.macrothink.org/journal/index.php/ijsw/article/view/5289>> [Accessed 28 April 2016]. doi:10.5296/ijsw.v1i1.528
- Lambert, M.J., 2013. *Bergin and Garfield's handbook of psychotherapy and behavior change*. Chichester: Wiley.
- Landy, R.J., 1983. The use of distancing in drama therapy. *The Arts in Psychotherapy*, 10(3), pp.175–185.
- Landy, R.J., 1991. The dramatic basis of role theory. *The Arts in Psychotherapy*, 18(1), p.29–41. doi:10.1016/0197-4556(91)90005-u
- Landy, R.J., 1993. *Persona and performance: the meaning of role in theatre, therapy and everyday life*. London: Guilford.
- Landy, R.J., 2006. The future of drama therapy. *The Arts in Psychotherapy*, 33(2), pp.135–142.
- Landy, R.J., 2008. *The couch and the stage: integrating words and action in psychotherapy*. Lanham, MD: Jason Aronson.
- Landy, R.J., 2010. Drama as a means of preventing post-traumatic stress following trauma within a community. *Journal of Applied Arts & Health*, 1(1), pp.7-18.
- Landy, R.J., and Butler, J., 2012. Assessment through role theory. *Assessment in drama therapy*, pp.148-176.
- Landy, R.J., Luck, B., Conner, E., and McMullian, S., 2003. Role profiles: a drama therapy assessment instrument. *The Arts in Psychotherapy*, 30(3), pp.151–161.
- Langley, D., 2006. *An introduction to dramatherapy*. London: Sage.

Larkin, M. and Thompson, A., 2012. Interpretative phenomenological analysis. *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*, pp.99-116.

Lawn, S., Battersby, M.W., Pols, R.G., Lawrence, J., Parry, T. and Urukalo, M., 2007. The mental health expert patient: findings from a pilot study of a generic chronic condition self-management programme for people with mental illness. *International Journal of Social Psychiatry*, 53(1), pp.63-74.

Leach, C., and Lucock, M., 2007. Using CORE to research outcome measurement. In: *CORE: a decade of development*. Rugby: CORE IMS. pp. 22–23.

Leavy, P., 2009. *Method meets art: arts-based research practice*. London: Guilford Press.

Leckey, J., 2011. The therapeutic effectiveness of creative activities on mental well-being: a systematic review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 18(6), pp.501–509.

Leeds, A.M. and Shapiro, F., 2000. EMDR and resource installation: Principles and procedures for enhancing current functioning and resolving traumatic experiences. *Brief therapy strategies with individuals and couples*, pp.469-534.

Leese, P., 2001. Essay review: making shell-shock. *British Journal of Psychology*, 92(2), pp.411–415.

Levine, P.A., 1997. *Waking the tiger: healing trauma : the innate capacity to transform overwhelming experiences*. Berkeley, CA: North Atlantic Books.

Levine, S.K., 2009. *Trauma, tragedy, therapy: the arts and human suffering*. London: Jessica Kingsley.

Levy, F.J., 1987. Dance/movement therapy: a healing art [online]. Available at: <<http://eric.ed.gov/?id=ED291746>> [Accessed 28 April 2016].

Levy, F.J., 1995. Foundations of dance/movement therapy: the life and work of Marian Chace. *The Arts in Psychotherapy*, 22(5), pp.501–503.

Linden, S.C., Jones, E. and Lees, A.J., 2013. Shell shock at Queen Square: Lewis Yealland 100 years on. *Brain*, 136(6), pp.1976–1988.

Liotti, G., 2004. Trauma, dissociation, and disorganized attachment: three strands of a single braid. *Psychotherapy: Theory, Research, Practice, Training*, 41(4), pp.472–486.

Lloyd, C., Waghorn, G. and Williams, P.L., 2008. Conceptualizing recovery in mental health rehabilitation. *British Journal of Occupational Therapy*, 71(98), pp.321–328. doi: 10.1177/030802260807100804.

Loughran, T., 2012. Shell shock, trauma, and the First World War: the making of a diagnosis and its histories. *Journal of the history of medicine and allied sciences*, 67(1), pp.94-119.

Macmanus, D., Jones, N., Wessely, S., Fear, N.T., Jones, E. and Greenberg, N., 2014. The mental health of the UK Armed Forces in the 21st century: resilience in the face of adversity. *Journal of the Royal Army Medical Corps*, 160(2), pp.125–130.

Macran, S., Ross, H. and Hardy, G.E., 1999. The importance of considering clients' perspectives in psychotherapy research. *Journal of Mental Health*, 6(4), pp.325–337.

Mann, S., 1996. Metaphor, symbol and the healing process in dramatherapy. *Dramatherapy*, 18(2), pp.2–5.

Martin, W., 2008. Trust circle and cradle body-centered approaches to help men access and heal emotions in groups. In: Sori, C.F. and Hecker, L.H., *The therapist's notebook volume 3: more homework, handouts, and activities for use in psychotherapy*. London: Routledge.

McAllister, P., Greenberg, N. and Henderson, M., 2011. Occupational psychiatry in the armed forces: should depressed soldiers carry guns? *Advances in Psychiatric Treatment*, 17(5), pp.350–356.

McDevitt-Murphy, M., 2014. Drinking motives among heavy-drinking veterans with and without posttraumatic stress disorder. *Addiction Research & Theory*, 23(2), pp.148–155. doi: /10.3109/16066359.2014.949696

McFarland, L., Barlow, J. and Turner, A., 2009. Understanding metaphor to facilitate

emotional expression during a chronic disease self-management course. *Patient education and counseling*, 77(2), pp.255-259.

McGeorge, T., Hacker, J. and Wessely, S., 2006. The MoD PTSD decision: a psychiatric perspective. [pdf] Available at: <[http://www.simonwessely.com/Downloads/Publications/Military/other/Mcgeorge 2006 - mod pstd.pdf](http://www.simonwessely.com/Downloads/Publications/Military/other/Mcgeorge%202006%20mod%20pstd.pdf)> [Accessed 28 April 2016].

McKenzie, A.G., 2012. Anaesthetic and other treatments of shell shock: World War I and beyond. *Journal of the Royal Army Medical Corps*, 158(1), pp.29–33.

McLaughlin, H., 2009. What's in a name: 'client', 'patient', 'customer', 'consumer', 'expert by experience', 'service user'—what's next?. *British Journal of Social Work*, 39(6), pp.1101–1117.

McLeod, S.A., 2007. Nomothetic Idiographic debate in psychology – *Simply Psychology* [online]. Available at <<http://www.simplypsychology.org/nomothetic-idiographic.html>> [Accessed 29 April 2016].

McNiff, S., 1992. *Art as medicine*. Boston, MA: Shambhala.

McNiff, S., 1998. *Art-based Research: Shaun McNiff*. London: Jessica Kingsley.

Meagher, R.E., 2006. *Herakles gone mad: Rethinking heroism in an age of endless war*. Northampton, MA: Interlink Books.

Mearns, D. and Thorne, B., 2000. *Person-centred therapy today: New frontiers in theory and practice*. Sage.

Merleau-Ponty, M., 2012 [1945]. *The Phenomenology of Perception*. Translated by Donald A. Landes. London: Routledge.

Mertens, D.M., 2010. Divergence and mixed methods. *Journal of Mixed Methods Research*, 4(1), pp.3–5.

Miller, R.J. II, and Johnson, D.R., 2012. The capacity for symbolization in posttraumatic stress disorder. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4(1),

pp.112–116.

Monson, C.M., Gradus, J.L., Young-Xu, Y., Schnurr, P.P., Price, J.L. and Schumm, J.A., 2008. Change in posttraumatic stress disorder symptoms: do clinicians and patients agree? *Psychological Assessment*, 20(2), pp.131–138.

Morgan, D.L., 1997. *Focus groups as qualitative research*. London: Sage.

Morgenstern, J. and Longabaugh, R., 2000. Cognitive-behavioral treatment for alcohol dependence: a review of evidence for its hypothesized mechanisms of action. *Addiction*, 95(10):1475–1490.

Morie, J.F., Haynes, E. and Chance, E., 2011. Warriors' journey: a path to healing through narrative exploration. *International Journal on Disability and Human Development*, 10(1), pp.17-23.

Morris, N., 2014. Silenced in childhood: A survivor of abuse finds her voice through group Dramatherapy. *Dramatherapy*, 36(1), pp.3–17.

Moustakas, C.E., 1994. *Phenomenological research methods*. London: Sage.

Mueser, K.T., Salyers, M.P., Rosenberg, S.D., Ford, J.D., Fox, L. and Carty, P., 2001. Psychometric evaluation of trauma and posttraumatic stress disorder assessments in persons with severe mental illness. *Psychological Assessment*, 13, pp.110–117.

Murrison, A., 2010. Fighting fit: a mental health plan for servicemen and veterans. Policy paper, London: Ministry of Defence. Available at: <https://www.gov.uk/government/publications/fighting-fit-a-mental-health-plan-for-servicemen-and-veterans--2> [Accessed 28 April 2016].

Myers, C., 1916. Contributions to the study of shell shock. *The Lancet*, 187(4829), pp.608–613.

NICE, 2005. Post-traumatic stress disorder (PTSD): full guideline, including appendices 1-13. NICE guidelines CG26 [pdf] Available at: <http://guidance.nice.org.uk/CG26/Guidance/pdf/English> [Accessed 28 April 2016].

NICE, 2011. *Commissioning stepped care for people with common mental health disorders* [pdf], Available from <http://pathways.nice.org.uk/pathways/post-traumatic-stress-disorder>, pathway last updated: 24 November 2015 [Accessed 30 April 16].

Odell-Miller, H., Hughes, P. and Westacott, M., 2006. An investigation into the effectiveness of the arts therapies for adults with continuing mental health problems. *Psychotherapy Research*, 16(1), 122–139.

Office for National Statistics, 2012. Mortality statistics : Metadata. ONS. [pdf] [online]. Available at: www.ons.gov.uk/ons/guide-method/user-guidance/health-and-life-events/mortality-metadata.pdf [Accessed 25 August 2016].

Office for National Statistics, 2014. *Suicides in the UK. 2012 registrations* [pdf] [online], Available at: http://www.ons.gov.uk/ons/dcp171778_351100.pdf [Accessed 28 April 2016].

Olsen, W., 2004. Triangulation in social research: qualitative and quantitative methods can really be mixed. In: H. M. Holborn, ed., *Developments in sociology*. Ormskirk: Causeway Press.

Onwuegbuzie, A.J. and Leech, N.L., 2007. Validity and qualitative research: An oxymoron?. *Quality & Quantity*, 41(2), pp.233-249.

Orne, M.T. (1962). On the social psychology of the psychological experiment: With particular reference to demand characteristics and their implications. *American Psychologist*, 17, 776-783.

O'Rourke, J.J.F., Tallman, B. A. and Altmaier, E.M., 2008. Measuring post-traumatic changes in spirituality/religiosity. *Mental Health, Religion & Culture*, 11(7), pp.719–728.

Orr, S., McNally, R., Rosen, G.M. and Shalev, A.Y., 2004. Psychophysiologic reactivity: implications for conceptualizing PTSD. In: G. Rosen, ed., *Posttraumatic Stress Disorder: issues and controversies*. Ch.6. [pdf] [online]. Available at: <http://www.al-edu.com/wp-content/uploads/2014/05/Rosen-ed-Posttraumatic-Stress-Disorder-Issues-and-Controversies.pdf> [Accessed 28 April 2016].

- Osborne, J.W., 1994. Some similarities and differences among phenomenological and other methods of psychological qualitative research. *Canadian Psychology/Psychologie canadienne*, 35(2), pp.167–189.
- Ozer, E.J. and Weiss, D.S., 2004. Who develops posttraumatic stress disorder? *Current Directions in Psychological Science*, 13(4), pp.169–172.
- Ozer, E.J., Best, S.R., Lipsey, T.L. and Weiss, D.S., 2003. Predictors of posttraumatic stress disorder and symptoms in adults: a meta-analysis. *Psychological Bulletin*, 129, pp.52–73.
- Pelaprat, E. and Cole, M., 2011. “Minding the Gap”: Imagination, creativity and human cognition. *Integrative Psychological and Behavioral Science*, 45(4), pp.397–418.
- Palmer, M., Larkin, M., de Visser, R. and Fadden, G., 2010. Developing an Interpretative Phenomenological Approach to focus group data. *Qualitative Research in Psychology*, 7(2), pp.99–121. doi:10.1080/14780880802513194
- Palmer, B.S., Bennewith, O., Simkin, S., Cooper, J., Hawton, K., Kapur, N. and Gunnell, D., 2014. Factors influencing coroners’ verdicts: an analysis of verdicts given in 12 coroners’ districts to researcher-defined suicides in England in 2005. *Journal of Public Health*, 37(1), pp.157–165. doi: 10.1093/pubmed/fdu024
- Payne, H., 1993. From practitioner to researcher. Research as a learning process. *Handbook of inquiry in the arts therapies: One river, many currents*, pp.16–40.
- Pearlman, L.A. and Courtois, C.A., 2005. Clinical applications of the attachment framework: relational treatment of complex trauma. *Journal of Traumatic Stress*, 18(5), pp.449–459.
- Pendzik, S., 2006. On dramatic reality and its therapeutic function in drama therapy. *The Arts in Psychotherapy*, 33(4), pp.271–280.
- Philips, B., 2009. Comparing apples and oranges: how do patient characteristics and treatment goals vary between different forms of psychotherapy? *Psychology and Psychotherapy: Theory, Research and Practice*, 82(3), pp.323–336.

doi:10.1348/147608309X431491

Pinder, R.J., Iversen, A.C., Kapur, N., Wessely, S. and Fear, N.T., 2011. Self-harm and attempted suicide among UK Armed Forces personnel: results of a cross-sectional survey. *International Journal of Social Psychiatry*. doi:10.1177/0020764011408534

Pinder, R.J., Greenberg, N., Boyko, E.J., Gackstetter, G.D., Hooper, T.I., Murphy, D., Ryan, M.A.K., Smith, B., Smith, T.C., Wells, T.S. and Wessely, S., 2012. Profile of two cohorts: UK and US prospective studies of military health. *International Journal of Epidemiology*, 41(5), pp.1272–82.

Pitman, A., Krysinaka, K., Osborn, D. and King, M., 2012. Suicide in young men. *The Lancet*, 379(9834):2383--2392. doi:10.1016/S0140-6736(12)60731-4.

Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M.R. and Rahman, A., 2007. No health without mental health. *The Lancet*, 370(9590), pp. 859–877.

Propp, V.: Morphology of a Folktale. Trans. Scott, L. Ed. Wagner, L. 2nd (Ed). Univ. Texas Press (1968).

Propp, V., Wagner, L. and Scott, L. (1969). *Morphology of the folk tale*. 1st ed. Austin, Tex.: University of Texas Press.

Quail, J.M., and Peavy, R.V., 1994. A phenomenologic research study of a client's experience in art therapy. *The Arts in psychotherapy*, 21(1), pp.45–57.

Redfern, M., 2014. Safe spaces and scary encounters: core therapeutic elements of trauma-informed dramatherapy. In: D. Sajnani and N. Johnson, ed., *Trauma-informed drama therapy: transforming clinics, classrooms, and communities*, Springer: ILL: Charles C. Thomas, pp.365–388.

Reason, P. and Riley, S., 2003. Cooperative inquiry. *Qualitative psychology: A practical guide to research methods*, pp.205–231.

- Reid, F., 2014. 'His nerves gave way': shell shock, history and the memory of the First World War in Britain. *Endeavour*, 38(2), pp.91–100. Available at: <www.sciencedirect.com/science/article/pii/S0160932714000210> [Accessed 9 August 2016].
- Ricoeur, P., 1967. *Husserl: An analysis of his phenomenology*. Evanston, IL: Northwestern University Press.
- Riley, S., 2004. Embodied perceptual practices: Towards an embrained and embodied model of mind for use in actor training and rehearsal. *Theatre Topics*, 445–471.
- Rivers, W.H.R., 1918. The repression of war experience. *Proceedings of the Royal Society of Medicine*, 11(Sect Psych), p.1.
- Rizq, R. and Target, M., 2010. 'If that's what I need, it could be what someone else needs.' Exploring the role of attachment and reflective function in counselling psychologists' accounts of how they use personal therapy in clinical practice: a mixed methods study. *British Journal of Guidance & Counselling*, 38(4), pp.459–481.
- Rona, R., Jones, M., Iversen, A., Hull, L., Greenberg, N., Fear, N.T., Hotopf, M. and Wessely, S., 2009. The impact of posttraumatic stress disorder on impairment in the UK military at the time of the Iraq war. *Journal of Psychiatric Research*, 43(6), pp. 649–655.
- Rona, R.J., Jones, M., Sundin, J., Goodwin, L., Hull, L., Wessely, S. and Fear, N.T., 2012. Predicting persistent posttraumatic stress disorder (PTSD) in UK military personnel who served in Iraq: a longitudinal study. *Journal of Psychiatric Research*, 46(9), pp.1191–1198.
- Roten, R.G., 2007. DSM-IV and the taxonomy of roles: How can the taxonomy of roles complement the DSM-IV to create a more holistic diagnostic tool?. *The Arts in psychotherapy*, 34(1), pp.53–68.
- Rothschild, B., 2003. *The body remembers casebook: unifying methods and models in the treatment of trauma and PTSD*. New York: Norton.
- Rowley, J., 2002. Using case studies in research. *Management Research News*, 25(1), pp.16–27.

Royal College of Psychiatrists, 2013. *Post-traumatic Stress Disorder* [leaflet] Available at: <<http://www.rcpsych.ac.uk/expertadvice/problemsdisorders/posttraumaticstressdisorder.aspx>> [Accessed 28 April 2016].

Sajnani, N. and Johnson, D., 2014. *Trauma-informed drama therapy: transforming clinics, classrooms, and communities*. Springer, IL: Charles C Thomas.

Samele, C., 2013. *The mental health of serving and ex-Service personnel*. [pdf] Mental Health Foundation. Available at: <<https://www.mentalhealth.org.uk/sites/default/files/the-mental-health-of-serving-and-ex-service-personnel.pdf>> [Accessed 28 April 2016].

Sandel, S., Chaiklin, S. and Lohn, A., 1993. *Foundations of dance/movement therapy: the life and work of Marian Chace*. Columbia, MD: American Dance Therapy Association.

Sareen, J. and Belik, S.-L., 2009. The need for outreach in preventing suicide among young veterans. *PloS medicine*, 6(3), p.e35. doi:/10.1371/journal.pmed.1000035

Schiraldi, G., 2009. *The post-traumatic stress disorder sourcebook: A guide to healing, recovery, and growth*. McGraw Hill Professional.

Seligman, M.E., Rashid, T. and Parks, A.C., 2006. Positive psychotherapy. *American psychologist*, 61(8), p.774.

Shapiro, F. and Maxfield, L., 2002. Eye movement desensitization and reprocessing (EMDR): Information processing in the treatment of trauma. *Journal of clinical Psychology*, 58(8), pp.933-946.

Sharpless, B.A. and Barber, J.P., 2011. A clinician's guide to PTSD treatments for returning veterans. *Professional Psychology: Research and Practice*, 42(1), pp.8–15.

Shay, J., 2002. *Odysseus in America: combat trauma and the trials of homecoming*. New York: Simon and Schuster.

Shay, J., 2010. *Achilles in Vietnam: combat trauma and the undoing of character*. New York: Simon and Schuster.

- Sheehan, W., Roberts, R.J., Thurber, S. and Roberts, M.A., 2009. Shell-shocked and confused: a reconsideration of Captain Charles Myers' case reports of shell-shock in World War One. *Priory Psychiatry Journal* [online]. Available at: <<http://www.priory.com/psychiatry/PTSDshellshock.htm>> [Accessed 15 August 2016].
- Sherman, N., 2007. *Stoic warriors: The ancient philosophy behind the military mind*. Oxford University Press.
- Shevlin, M., Houston, J.E., Dorahy, M.J. and Adamson, G., 2008. Cumulative traumas and psychosis: an analysis of the national comorbidity survey and the British Psychiatric Morbidity Survey. *Schizophrenia Bulletin*, 34(1), pp.193–199.
- Shinebourne, P., 2011. The theoretical underpinnings of interpretative phenomenological analysis (IPA). *Existential Analysis*, 22, pp.16–31.
- Shinebourne, P., and Smith, J.A., 2010. The communicative power of metaphors: an analysis and interpretation of metaphors in accounts of the experience of addiction. *Psychology and Psychotherapy*, 83(1), pp.59–73.
- Slade, P., 1955. *Child drama*. Michigan: Philosophical library.
- Smeijsters, H. and Aasgaard, T., 2005. Qualitative case study research. In: B. Wheeler, ed., *Music therapy research*. London: Jossey-Bass, pp.39–54.
- Smith, J.A., 2004. Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1(1), pp.39–54.
- Smith, J.A., 2011. 'We could be diving for pearls': The value of the gem in experiential qualitative psychology. *Qualitative Methods in Psychology Bulletin*, 12, pp.6–15.
- Smith, J.A., 2015. *Qualitative psychology: a practical guide to research methods*. London: Sage.
- Smith, J.A., and Eatough, V., 2007. Interpretative Phenomenological Analysis. In: A. Lyons and E. Coyle, ed., *Analysing qualitative data in psychology*. London: Sage, pp.35–50.

Smith, J.A., Flowers, P., and Larkin, M., 2009. *Interpretative phenomenological analysis: theory, method and research*. London: Sage.

Smith, T.C., Ryan, M.A.K., Wingard, D.L., Slymen, D.J., Sallis, J.F. and Kritz-Silverstein, D., 2008. New onset and persistent symptoms of post-traumatic stress disorder self reported after deployment and combat exposures: prospective population based US military cohort study. *British Medical Journal (Clinical research)*, 336(7640), pp.366–71.

Smolucha, F., 1992. A reconstruction of Vygotsky's theory of creativity. *Creativity Research Journal*, 5(1), pp.49-67.

Spandler, H. and Stickley, T., 2011. No hope without compassion: the importance of compassion in recovery-focused mental health services. *Journal of Mental Health*, 20(6), pp.555–566.

Spinazzola, J., Blaustein, M. and Van Der Kolk, B.A., 2005. Posttraumatic stress disorder treatment outcome research: The study of unrepresentative samples? *Journal of Traumatic Stress*, 18(5), pp.425–436.

Shacham, M. and Lahad, M., 2004. Stress reactions and coping resources mobilized by children under shelling and evacuation. *Australasian Journal of Disaster and Trauma Studies*, 2(ISSN), pp.1174-4707.

Stewart-Brown, S., Tennant, A., Tennant, R., Platt, S., Parkinson, J., and Weich, S., 2009. Internal construct validity of the Warwick-Edinburgh mental well-being scale (WEMWBS): a Rasch analysis using data from the Scottish health education. *Health and Quality of Life Outcomes*, 7, p.15. doi:10.1186/1477-7525-7-15

Strachan, H., 2003. The civil–military ‘gap’ in Britain. *Journal of Strategic Studies*, 26(2), pp.43–63. doi:10.1080/01402390412331302975

Strauss, A.L. and Corbin, J.M., 1998. *Basics of qualitative research: techniques and procedures for developing grounded theory*. London: Sage.

Sundin, J. Fear, N.T. Iversen, A., Rona, R. J. and Wessely S. 2010. PTSD after deployment to Iraq: conflicting rates, conflicting claims. *Psychological Medicine*, 40, pp 367-382.

doi:10.1017/S0033291709990791.

Sundin, J., Herrell, R.K., Hoge, C.W., Fear, N.T., Adler, A.B., Greenberg, N., Riviere, L.A. Thomas, J.L., Wessely, S. and Bliese, P.D., 2014. Mental health outcomes in US and UK military personnel returning from Iraq. *British Journal of Psychiatry: the Journal of Mental Science*, 204, pp.200–207.

Sutton, J., ed. 2002. *Music, music therapy and trauma: international perspectives*. London: Jessica Kingsley.

Swift, T.L. and Dieppe, P.A., 2005. Using expert patients' narratives as an educational resource. *Patient education and counseling*, 57(1), pp.115–121.

Tedeschi, R.G. and Calhoun, L.G., 2004. Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological inquiry*, 15(1), pp.1-18.

Tedeschi, R.G. and McNally, R.J., 2011. Can we facilitate posttraumatic growth in combat veterans?. *American Psychologist*, 66(1), p.19.

Thomas, J.L., Wessely, S. and Bliese, P.D., 2014. Mental health outcomes in US and UK military personnel returning from Iraq. *British Journal of Psychiatry: the Journal of Mental Science*, 204, pp.200–207.

Tselikas-Portmann, E. ed., 1999. *Supervision and dramatherapy*. London: Jessica Kingsley.

Talwar, S., 2007. Accessing traumatic memory through art making: an art therapy trauma protocol (ATTP). *The Arts in Psychotherapy*, 34(1), pp.22–35.

Teddlie, C., and Tashakkori, A., eds., 2009. *Foundations of mixed methods research: integrating quantitative and qualitative approaches in the social and behavioral sciences*. London: Sage.

Thomas, G., 2010. *How to do your case study: a guide for students and researchers*. London: Sage.

Thomas, G., 2011. A typology for the case study in social science following a review of definition, discourse, and structure. *Qualitative Inquiry*, 17(6), pp.511–521.

- Tomkins, L., and Eatough, V., 2010. Reflecting on the use of IPA with focus groups: pitfalls and potentials. *Qualitative Research in Psychology*, 7(3), pp.244–262.
- Turner, V.W., 1967. *The forest of symbols: Aspects of Ndembu ritual*. New York: Cornell University Press.
- Turner, V.W., 1975. *Drama, fields, and metaphors: symbolic action in human society*. New York: Cornell University Press.
- Turner, V.W. and Schechner, R., 1988. *The anthropology of performance*. New York: Paj Publications.
- Tyreman, S., 2005. The expert patient: outline of UK government paper. *Medicine, Health Care and Philosophy*, 8(2), pp.149–151.
- Unsworth, G., Cowie, H. and Green, A., 2012. Therapists' and clients' perceptions of routine outcome measurement in the NHS: A qualitative study. *Counselling and Psychotherapy Research*, 12(1), pp.71–80.
- van der Kolk, B., 1994. The body keeps the score: memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry*, 1(3), pp.253–265.
- van der Kolk, B.A., 1996. Trauma and memory. In: B.A. van der Kolk, A.C. McFarlane and L. Weisaeth (eds) *Traumatic stress: the effects of overwhelming experience on mind*. London: Guilford Press.
- van der Kolk, B.A., 2005. Disorders of extreme stress: the empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*, 18(5), pp.389–399.
- van der Kolk, B.A., 2006. Clinical implications of neuroscience research in PTSD. *Annals of the New York Academy of Sciences*, 1071, pp.277–93.
- van der Kolk, B., McFarlane, A., and Weisaeth, L., 2012. *Traumatic stress: the effects of overwhelming experience on mind, body, and society*. 2nd ed. London: Guilford Press.
- Van Gennep, A., 1966. *The Rites of Passage: Transl. by Monika B. Vizedom and Gabrielle L. Caffee. Introd. by Solon T. Kimball*. University of Chicago Press.

van Hoorn, L.A., Jones, N., Busuttil, W., Fear, N.T., Wessely, S., Hunt, E. and Greenberg, N., 2013. Iraq and Afghanistan veteran presentations to combat stress, since 2003. *Occupational Medicine* 63(3), pp.238–41.

van Manen, M., 1990. *Researching lived experience: human science for an action sensitive pedagogy*. The State University of New York: New York.

Vygotsky, L.S. 1930/1967. Trans. Smolucha, F., 1992 *Voobrazhenie i tvorchestvo v detskom vozraste: Imagination and Creativity in Childhood*. Moscow: Prosvescheniye.

Wagstaff, C., Jeong, H., Nolan, M., Wilson, T. Tweedlie, J., Phillips, E., Senu, H. and Holland, F. 2014. The accordion and the deep bowl of spaghetti: eight researchers' experience of using IPA as a methodology. *The Qualitative Report*, 19(24), pp.1–15.

Walters, A.S. and Hening, W.A., 1992. Noise-induced psychogenic tremor associated with post-traumatic stress disorder. *Movement Disorders*, 7, pp.333–338.

Warne, T. and McAndrew, S., 2007. Passive patient or engaged expert? Using a Ptolemaic approach to enhance mental health nurse education and practice. *International Journal of Mental Health Nursing*, 16(4), pp.224–229.

Weathers, F., Huska, J., and Keane, T., 1991. *The PTSD checklist military version (PCL-M)*. Boston, MA: National Centre for PTSD.

Weathers, F.W., Keane, T.M. and Davidson, J.R., 2001. Clinician–Administered PTSD Scale: A review of the first ten years of research. *Depression and anxiety*, 13(3), pp.132–156.

Webb, T.E.F., 2006. 'Dottyville' – Craiglockhart War Hospital and shellshock treatment in the First World War. *Journal of the Royal Society of Medicine*, 99(7), pp.342–6.

Wells, T.S., Miller, S.C., Adler, A.B., Engel, C.C., Smith, T.C. and Fairbank, J.A., 2011. Mental health impact of the Iraq and Afghanistan conflicts: a review of US research, service provision and programmatic responses. *International Review of Psychiatry*, 23,

pp.144–152.

Wertz, F.J., 2005. Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology*, 52(2), p.167–177.

Wessely, S. and Dandeker, C., 2010. *King's Centre for Military Health Research – A fifteen year report*. [pdf] [online]. Available at:
<<https://www.kcl.ac.uk/kcmhr/publications/15YearReportfinal.pdf>> [Accessed 11 Nov. 2014].

While, D., Bickley, H., Roscoe, A., Windfuhr, K., Rahman, S., Shaw, J., Appleby, L. and Kapur, N., 2012. Implementation of mental health service recommendations in England and Wales and suicide rates, 1997–2006: a cross-sectional and before-and-after observational study. *The Lancet*, 379, pp.1005–1012.

Widdershoven, G., 2000. The doctor–patient relationship as a Gadamerian dialogue: a response to Arnason. *Medicine, Health Care and Philosophy*, 3(1), pp.25–27.

Wigram, T., Pedersen, I.N. and Bonde, L.O., 2002. *A comprehensive guide to music therapy: theory, clinical practice, research and training*. London: Jessica Kingsley. (First published in Danish, 2001.)

Wilkins, K., Lang, A. and Norman, S., 2011. Synthesis of the psychometric properties of the PTSD checklist (PCL) military, civilian, and specific versions. *Depression and Anxiety*, 28(7), pp.596–606.

Wilson, P.H., 2008. Defining military culture. *The Journal of Military History*, 72(1), pp.11–41.

Windfuhr, K. and Kapur, N., 2011. Suicide and mental illness: A clinical review of 15 years findings from the UK National Confidential Inquiry into Suicide. *British Medical Bulletin*, 100, pp.101–121.

Windfuhr, K., While, D., Hunt, I., Turnbull, P., Lowe, R., Burns, J., Swinson, N., Shaw, J., Appleby, L., Kapur, N., Ashton, A., Stones, P., Hadfield, K., Daud, H., Flynn, S., Rodway,

C., Roscoe, A., Bickley, H., Pearson, A., Saini, P. and Da Cruz, D., 2008. Suicide in juveniles and adolescents in the United Kingdom. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 49, pp.1155–1165.

Winn, L., 1994. *Post traumatic stress disorder and dramatherapy: treatment and risk reduction*. London: Jessica Kingsley.

Winn, L.C., 1998. Towards a model of dramatherapy for the assessment and treatment of PTSD. University of Exeter, unpublished M.Phil thesis.

Winn, L.C., 2011. Post-traumatic stress disorder and drama therapy. In: *The REAL (Rehearsal, Embodiment, Action, Living) model applied in the recovery for the treatment of trauma*. Proceedings of the 3rd Annual Conference of the Romanian Play Therapy and Dramatherapy Association, Brasov, Romania.

Wilson, P.M., Kendall, S. and Brooks, F., 2007. The Expert Patients Programme: a paradox of patient empowerment and medical dominance. *Health & Social Care in the Community*, 15(5), pp.426–438.

Woodhead, C., Rona, R.J., Iversen, A., MacManus, D., Hotopf, M., Dean, K., McManus, S., Meltzer, H., Brugha, T., Jenkins, R., Wessely, S. and Fear, N.T., 2011a. Mental health and health service use among post-national service veterans: results from the 2007 Adult Psychiatric Morbidity Survey of England. *Psychological medicine*, 41, pp.363–372.

Woodhead, C., Rona, R.J., Iversen, A.C., MacManus, D., Hotopf, M., Dean, K., McManus, S., Meltzer, H., Brugha, T., Jenkins, R., Wessely, S. and Fear, N.T., 2011b. Health of national service veterans: an analysis of a community-based sample using data from the 2007 Adult Psychiatric Morbidity Survey of England. *Social Psychiatry and Psychiatric Epidemiology*, 46, pp.559–566.

Yarvis, J.S., Yoon, E., Ameuke, M., Simien-Turner, S. and Landers, G., 2012. Assessment of PTSD in older veterans: the posttraumatic stress disorder checklist: military version (PCL-M). *Advances in Social Work*, 13(1), 185–202.

Yealland, L.R., 1923. Hysterical fits, with some reference to their treatment. *Proceedings of the Royal Society of Medicine*, 16 (Neurology Section), pp.85–94.

Yin, R.K., 2012. *Applications of case study research*. 3rd ed. London: Sage.

Yin, R.K., 2013. *Case study research: design and methods*. 5th ed. London: Sage.

Young, A., 1997. *The harmony of illusions: inventing post-traumatic stress disorder*. Princeton University Press.

Young, A., 2004. When traumatic memory was a problem: on the historical antecedents of PTSD. In: G.M. Rosen, ed., *Posttraumatic stress disorder: issues and controversies*. Chichester: Wiley, pp.127–146.

APPENDICES

Appendix 1 Homer's Odyssey Extracts

Individual session text reading (Armitage, 2010)

First extract

HOMEWARD BOUND

SAILOR

The sun rising just as we near land. Perfect timing.

SKIPPER

And look – the morning star – a good sign.

SAILOR

Do you know this coast?

SKIPPER

I came here fishing once.

SAILOR

Where's the best place to land?

SKIPPER

Right here, pretty much, between these jutting promontories.

The ocean bed runs smoothly right up to the beach.

It's a natural harbour

SAILOR

Will he be safe here?

SKIPPER

He's the king, isn't he? This is his land. Why should he fear?

SAILOR

Kings don't usually come home by the back door. He might be mistaken

for a spy or pirate and strung up.

SKIPPER

It's not our job to worry about these things. Here we go. Punt on till we scrape the bottom, then everyone out and drag it up the beach

They haul the boat into the sand.

SKIPPER

OK. Well done. Where is he?

SAILOR

Asleep, look. Under this canvas

SKIPPER

Don't wake him, then. You others, pile the treasure out of reach of the sea.

SAILOR

Twenty years away from home – I wanted to see his face.

SKIPPER

No, let him rest.

SAILOR

What's the longest you've ever been away for?

SKIPPER

Twelve weeks. Felt like forever.

SAILOR

So what must this be like?

I bet even his own dog won't remember him.

SKIPPER

I can't think that a man like this will have been forgotten.

SAILOR

The world turns. Fashions change. People move on.

SKIPPER

Some things are worth waiting for.

SAILOR

No one would wait that long for me.

SKIPPER

We'll bear him down on this pallet

and set off down on the beach.

They lift Odysseus from the boat and leave him sleeping on the shore

SAILOR

Sure we shouldn't wake him?

SKIPPER

No. This seems right.

Throw the canvas back over his shoulders.

SAILOR

It'll be like waking up from a coma.

Like coming back from the dead.

SKIPPER

All unloaded?

One big shove then to cast off.

Good luck, tired Odysseus. Sleeping King of Ithaca.

Welcome home.

OLYMPUS

ATHENA

Zeus? Father?

ZEUS

I'm resting.

ATHENA

It won't exhaust you to turn your head.

Look down through the clouds. What do you see?

ZEUS

Nothing. It's misty.

ATHENA

Wait a moment.

(She blows the clouds apart.)

Now what you see? There, where I'm pointing.

ZEUS

An island.

ATHENA

Not just any island. Ithaca.

ZEUS

Has Athena taken to giving mighty Zeus lessons in geography?

ATHENA

Look at that beach on the West Coast.

That cove, between the two headlands.

Notice anything on the strandline?

ZEUS

Driftwood?

ATHENA

Of a kind.

ZEUS

No, it's something alive. A large squid is it? A dolphin?

ATHENA

It's a man.

ZEUS

Ah, and not just any man, I presume?

ATHENA

Look at the hands, the hair, the limbs beneath the clothes.

Odysseus, home after twenty years.

ZEUS

And now he sleeps like a foetus,

curled in a ball with his face buried in his chest.

Let's see if a few drops of rain might bring him round.

ATHENA

No, don't wake him.

ZEUS

Very well. The beautiful irony isn't lost on me.

The suffering hero arrives home in slumbering innocence.

ATHENA

But is he home for good, or does Poseidon
still chase him for his pound of flesh?

ZEUS

Who can say, in the great scheme of things?

Who can predict what might happen next?

Besides, your man, Odysseus –

he might be sleeping like a baby in the womb

but he rears up like a cobra when he's roused.

He blinded the Cyclops with a burning lance –

Poseidon's son! My nephew. Poseidon has a case.

ATHENA

He's your brother. Call him off.

ZEUS

I can't do that.

ATHENA

Then I'll go to Odysseus. I'll intervene.

ZEUS

Athena, not so fast.

ATHENA

He's served his time. I won't have him

clawed back into the sea by some freak wave.

ZEUS

You're being hasty – you're acting irrationally – like one
of them.

ATHENA

I'll guide him safely inland.

ZEUS

Well, if you must, you must. At least go in disguise.

ATHENA

I'll appear as a shepherd boy. Goodbye, father.

ZEUS

Goodbye, goodbye, goodbye.

She's right. Poor wretch of a man –

Twenty years an exile – enough is enough.

Odysseus will be spared.

But Poseidon bares his grudge like a birthright –

he'll have to be bought off.

So those Phaeacian oarsmen, who carried him

over the waves, whose craft still skims the surface

of Poseidon's watery fields... Who can say? Who can say?

[196 to 199]

ON THE BEACH AT ITHACA

A violent wave crashes in the distance as Poseidon wrecks the Phaeacian ship. The echo of it carries across the water, waking Odysseus from his sleep.

ODYSSEUS

What.. A dream.. The end of the world...

No, only a storm at sea.

A freak wave cracking the keel of some poor sailing ship.

Snapping it like a twig. Just the Gods doing their thing.

He stands and dusts himself down.

How long did I sleep? Too long. And too deep –

those sweet-talking Phaeacians. The moment

I closed my eyes they dumped me on the nearest beach.

Did they take away their gifts as well,

giving me with the right hand,

taking back with the left?

I bet they couldn't keep their fingers off this stash of loot.

He lays his hands on the riches' piled on the beach.

No, all here.

But what's the use of a golden brooch

or a ruby ring or a crown studded with precious stones

in a God-forsaken land. I'm discarded. A castaway.

I'm the king of nothing and nowhere again.

(shouts into the air)

I'M THE KING OF OBLIVION.

ATHENA *(disguised as a shepherd boy)*

You seem troubled, stranger. Are you lost?

ODYSSEUS *(surprised and flustered)*

Er... lost... yes. Shipwrecked. Thrown onto the beach.

Lost and a little bit delirious.

ATHENA

But the sea's been calm for weeks.

ODYSSEUS

It happened...some time and distance away. I drifted.

ATHENA

Lucky to be alive, then?

ODYSSEUS

Lucky beyond all imagining.

But my thoughts are in a mess – all my senses are fuddled.

The wind's whistled in my ear, the sun's warmed my
brain

And salt water has fouled my blood.

The workings of my mind out of kilter with the world.

I'm completely lost. I have to ask you – what Island is
this?

ATHENA

You mean you don't know?

ODYSSEUS

Hand on heart – I've no idea.

ATHENA

Then you're in worse shape than you think.

Don't you recognise this famous place,
with its rocky outcrops and jutting crags?

It's not huge, but it's rich in woodland
and birdlife, and the wells never run dry,

and crops and vines thrive in the deep soil,
the goats and cattle are fat with milk,
and herb season the air...

ODYSSEUS

No, I...

ATHENA

Breathe its smell – doesn't it strike home?

ODYSSEUS (*breathing in*)

I must admit there's something...

ATHENA

Say its name. Ithaca! It's famous everywhere –
even in Troy, and that's a world away. Say it.

ODYSSEUS (*astonished*)

Ithaca?

ATHENA

Don't say you haven't heard of it.

ODYSSEUS.

Ithaca. Ithaca? I...

(*concealing his feelings*)

I mean – yes, I've come across that name.

You see, I'm a sailor from Crete. With children
waiting for me, children with mouths to feed.

This pile of treasure, it's mainly for them.

I was sailing west when...

ATHENA

Odysseus – you’re cunning and wily, right to the last,
some might go as far as to call you sly.

But you can stop your twisting and turning now.

You’re no more a sailor from Crete, than I’m a shepherd boy.

ODYSSEUS

Who are you? What do you want?

ATHENA

Pallas Athena. Daughter of Zeus.

ODYSSEUS

My Goddess.

ATHENA

I’ve followed your fortunes, Odysseus.

Stood like a shield in front of you.

or at your shoulder in silence.

ODYSSEUS

I’ve felt your presence. You’ve been my lucky talisman.

ATHENA

No, much more.

I’ve been your pole star, and your armour plating.

Without me, you wouldn’t have made it this far.

You wouldn’t have lived.

ODYSSEUS

I can’t take it in.

I daren't let myself believe.

ATHENA

Believe it, Odysseus. You're home.

ODYSSEUS

My eyes begin to recognize the signs –

those stones...those plants... the birds...even the

clouds –

all images of Ithaca – all native to this land.

But my heart won't let it be true.

ATHENA

It's as true as the ground you kneel on.

Feel the sand. Pick it up. It's Ithaca – every last grain.

ODYSSEUS (*astonished*)

Ithaca – right here in my hand.

ATHENA

Which doesn't mean your journey is over.

Hordes of suitors are camped in your house,

loving the day your wife declares herself a widow –

your death would open the bedroom doors for one of

those hyenas.

And Penelope, who waits and waits,

you can't just go striding home after so long...

ODYSSEUS

I know. I need to prove myself to her.

She needs...

We need to prove ourselves to ourselves –
husband to wife.

ATHENA

Never impulsive. Clever like a cat.

Look, I'll bring down the mist – slip through its curtain.

Go and find Eumaeus, your old swineherd.

ODYSSEUS

What are you doing?

ATHENA

Odysseus wouldn't make it within a mile of his palace –
the suitors have their spies and their assassins.

But an old man,
with shrunken skin,
sagging limbs,
a head of silvery hair
and two dull stones in his eyes...

She transforms him into an old man.

ODYSSEUS

It's hardly how I imagined my return.
Tottering home, a wizened beggar.

ATHENA

There'll be no grand entrance.
Less self-consciousness and more self-preservation –

that's what's needed on this occasion.

ODYSSEUS

What about my son, Telemachus? Tell me about my son.

ATHENA

Follow the path to the right of the cliffs.

(Her voice trails off into the distance.)

Go now before the fog catches you in its net.

ODYSSEUS Athena, wait...

A nightmare twenty years in the wilds of the world.

Then I open my eyes and I'm home. I wake from sleep and I'm home.

[200-205]

Group text reading: THE LOYAL SWINEHERD

Odysseus approaches Eumaeus' farmstead. Dogs bark as he opens the gate and nears the door.

EUMAEUS *(from inside)*

Who's there? Who's trespassing on my land?

ODYSSEUS

A shipwrecked sailor, from Crete.

The tide washed me up on your shore.

I'm a friendly stranger. I don't mean any harm.

EUMAEUS *(opening the door)*

Friendly, eh? Oh, yes, there's no doubt about that.

ODYSSEUS *(thinking he may have been recognized)*

But you've never seen me before. How can you tell?

EUMAEUS

I can't, but these hounds can.

They've got a keen nose for that kind of thing.

They can smell danger from twenty fields away.

If you'd been a troublemaker, old-timer,

You'd be dog-meat by now.

ODYSSEUS

Then praise to all animals and their sense of right and wrong.

EUMAEUS

I'm a farmer – I praise animals every day.

Well come inside. It's no stately home but it's warm and dry.

They go inside the hut

EUMAEUS

Take the seat by the fire.

ODYSSEUS

Isn't that your seat?

EUMAEUS

Visitors have pride of place in this house.

This whole island's famous for its hospitality.

Better it wasn't – that's what I sometimes think.

ODYSSEUS

What can you mean by that?

EUMAEUS

Down at the palace.

It's crawling with spongers and layabouts,
dozens of them outstaying their welcome.
Scavengers they are. Dingoes.

ODYSSEUS

The head of the house must be a generous man.

EUMAEUS

The most generous I've ever known, and the wisest. Odysseus – do you know of him?

ODYSSEUS

Er... I've heard his name, of course.

EUMAEUS

A true king. And with vast wealth – land, cattle, crops, an army, a sailing fleet...

But he's missing, presumed dead.

Twenty years in his absence I tended his flocks
while the household's gone to rack and ruin.

ODYSSEUS

Does he have a family? A widow, perhaps.

EUMAEUS

Penelope – loyal as the moon to the earth.

But she can't hold out much longer.

Keeping those suitors at bay – it's like holding back a flood.

ODYSSEUS

No children to take up his role?

EUMAEUS

A fine son. Telemachus. He's abroad in search of his father – or his father's grave.

There's rumour he's back on the island,

but that's hope talking. Here, have a bowl of stew.

ODYSSEUS

You're a kind man. You offer me shelter and food without even asking my name.

EUMAEUS

I can see who you are.

ODYSSEUS

You can?

EUMAEUS

You're a workingman like me.

You've got a sun-beaten face and leather hands
and enough dirt under your fingernails to plant corn in.

You're old – older than me even!

You've lived a hard life under the stars – right?

ODYSSEUS

Right.

EUMAEUS

We're two of a kind then. What else is there to know? How's the stew?

ODYSSEUS

Everything I need. Bless you.

Outside, the dogs are excited.

Sounds like a stranger coming to your door.

EUMAEUS

More like a friend, I'd say, listening to those dogs – sounds like they're kissing his feet!

Another herdsman I'm over the hill, I'd guess.

There is a knock at the backdoor

Come in. Always room for one more.

Telemachus opens the door and stands in the doorway.

(delirious with excitement)

Telemachus Telemachus Telemachus!

TELEMACHUS

Eumaeus – loyal and trusted friend.

EUMAEUS

Telemachus Telemachus Telemachus!

Give thanks to the Gods and planets.

Telemachus Telemachus Telemachus!

Give thanks to a thousand stars.

Ho! Telemachus – wasn't I just singing his praises?

ODYSSEUS

To the sky.

TELEMACHUS

Who's the old man?

EUMAEUS

A wanderer – hungry and out of breath.

Telemachus Telemachus Telemachus!

A miracle – I'd only a minute ago spoken in your name!

Tell him, hadn't I just this second spoken his name?

ODYSSEUS

Not more than the moment since.

EUMAEUS

Tell me all about your trip. But first

This calls for a slap-up feast!

I'll skewer the juiciest pig in the pen.

Crank up the fire while I'm outside.

Oh, it's good see you, young man.

Telemachus Telemachus Telemachus...

Ha!

He goes outside, chuckling to himself.

TELEMACHUS

Well, I haven't seen happiness like that long while.

ODYSSEUS

You've put him in high spirits. He adores you.

TELEMACHUS

It's inherited glory. He adores my father more.

ODYSSEUS

Your father?

TELEMACHUS

Odysseus.

ODYSSEUS

Of course. Any news of your travels?

TELEMACHUS

Rumours. Gossip. Nothing solid.

I've told myself I might never see him again.

I'm prepared for the worst.

ODYSSEUS

Would you know him if he returned?

TELEMACHUS

I was only a baby when he left.

But they say he stands out. They say he's a man
above and beyond ordinary men, and unmistakable.

ODYSSEUS

You must... miss him.

TELEMACHUS

It hurts. A physical pain.

ODYSSEUS

He must miss you too, a fine son.

TELEMACHUS (*upset*)

If his heart still beats in his chest.

ODYSSEUS

I apologize. I'm only an old stranger. I've overstepped the mark.

TELEMACHUS

Your words weren't meant to harm, though.

You have kindness that shines through.

I'll... help Eumaeus catch his pig.

Telemachus leaves the hut.

ODYSSEUS (*to himself, his voice full of emotion*)

My son, my living flesh. My miraculous son.

Athena appears from nowhere

ATHENA

Do you hear me, Odysseus?

ODYSSEUS

Voices in the air?

No, I can't make out... who is it, standing in the dark corner?

Show your face.

ATHENA

It's time your son knows you for who you are.

Then the two of you can hatch a plan –

you'll know what to say, I've planted the seed in your head.

Time's running down.

Here – I fling magic at you.

I throw you back the strength in your bones,

and the colour in your hair,

and the smoothness in your skin,

and the straightness in your spine,

your supple limbs,

and here – here's fire your eyes,

and a worthy shirt to your shoulders.

Who wouldn't recognize you now, handsome Odysseus?

ODYSSEUS

One minute I'm a dull old man,

the next I'm shining like a king.

What will my son say?

ATHENA

Make the most of your appearance – it's just a fleeting glimpse.

Here comes Telemachus. I'll dissolve into air again.

Telemachus returns to the hut.

TELEMACHUS

There's a comical sight.

Those grunTERS are like greased lightning, and...

What's happening here? Your skin, your face...

ODYSSEUS

Don't be afraid, Telemachus.

TELEMACHUS

This is freakish. Supernatural.

ODYSSEUS

I'm the same person.

TELEMACHUS

No, you were a mortal – an old, withered man.

Now-you glow. Like... a God.

ODYSSEUS

I'm no God – just a man transformed by the touch of a Goddess.

Look at me Telemachus.

Who am I?

TELEMACHUS

You're a trickster. You'll put a spell on me.

ODYSSEUS

It's no trick. Look at me.

Who am I?

TELEMACHUS

You deceive me.

ODYSSEUS

LOOK AT ME. Look at me, Telemachus, my son.

TELEMACHUS

... Your son?

ODYSSEUS

What did you say, that Odysseus is unmistakable?

Then don't mistake him. Recognize him at once.

[206-214]

(Armitage, 2010) © Reproduced with kind permission Faber and Faber.

Appendix 2 British Armed Conflicts and Wars 1914–2014

1914 – 1918 World War I
1916 Ireland (Easter Rising)
1919 –1920 Somaliland
1919 –1921 Anglo-Irish war
1919 – 1939 North West Frontier; There were repeated clashes throughout the interwar years on the borderland between Afghanistan and India.
1927– 1939 China
1928 Aden
1928 Sudan
1929 — 1938 Palestine
1929 Kuwait
1939 – 1945 World War II
1944– 1946 Greek Civil War
1945– 1946 Dutch East Indies
1945–1946 French Indo-China
1948–1960 Malaya
1949 China
1948–1951 Eritrea
1950– 1953 Korea
1951–1954 Suez Canal Zone
1952–1960 Kenya (Mau Mau rising)
1953– 1954 British Guiana
1955– 1959 Cyprus
1956 Suez Crisis
1957 – 1959 Muscat and Oman
1960 – 1961 Cameroon
1961 Kuwait
1962 Brunei
1963–1966 Borneo
1963– 1976 Oman
1963 – 1967 Aden

1969– 1998 Northern Ireland (Troubles)
1982 Falklands
1990– 1991 First Gulf War
1992 – 1995 Bosnia
1999 Kosovo
2000 Sierra Leone
2001 – 2014 Afghanistan
2003– 2009 Iraq
2011 Libya

The historical and psychological context.

There is debate about the profile of mental health problems amongst veterans. Iversen and Greenberg (2009) draw attention to the fact that PTSD is the most publicised psychological illness experienced by service personnel, but depression, alcohol misuse and anxiety disorders are the most common diagnoses. This is echoed by the findings of a study of combat veterans being treated by a specialist NHS primary care psychological service for veterans (Giebel, Clarkson and Challis, 2014), but contrasts with figures from Combat Stress, a charity that specialises in the treatment of veterans with psychological problems (van Hoorn et al., 2013). In a Combat Stress audit, 114 combat veterans (who had served in Iraq and/or Afghanistan from 2003 to 2011) were assessed by a psychiatrist. The results (van Hoorn et al., 2013, p.239) showed a PTSD primary diagnosis in 76% of cases, with diagnoses of mixed anxiety and depression in another 15% and personality disorders in 09%. Further interrogation of the data showed that 78% of cases were given a single diagnosis, with the other 22% having a comorbid diagnosis (including alcohol and substance misuse). In addition 51% of patients had suffered physical trauma during service, whilst 0.7% were diagnosed with PTSD with depression and 0.2% with alcohol misuse.

The conflicting figures for the diagnosis of veterans suffering psychological injury illustrate the discussion of debates about PTSD in Chapter 1. UK Armed Forces mental health annual statistics (2013) are also problematic. The reason given for the 20% increase in incidence of psychological problems in 2012–13 is that the statistics changed from manual to electronic reporting systems. Further examination by MoD statisticians revealed that there had been errors during the digitalisation of manual records, leading to double reporting. They have advised that the results should be interpreted with caution. In a meta-analysis Sundin et al. (2010) examined 60 papers relating to UK armed forces personnel who had been deployed in the Iraq War. These excluded studies where people had been ‘help-seeking’ or ones with fewer than 300 participants. A total of 19 papers were examined in greater depth once the exclusion criteria had been applied, showing that the incidence of PTSD varied from 1.4 to 31%. Sundin et al. (2010) commented that anonymous surveys pointed to a greater incidence of PTSD in those involved in combat. Their study highlights the differences in incidence of PTSD and although based on the Iraq War it is a difficulty that occurs in other conflicts. Partly this is due to methodological difficulties in studying PTSD in combat veterans, since different methodologies and time

frames are used. Firstly, results will be affected by whether or not the veterans were conscripts. Research into military mental health has increased since 2000 and in the UK has been particularly focused on the Iraq and Afghanistan wars. The personnel within these military operations would not have been conscripted. There is likely to be a difference in motivational terms between individuals entering military service of their own volition and those who were required by statute, to participate in National Service (see Section 2.4). It may be argued that this will also cause a difficulty when analysing the incidence of trauma amongst veterans over a historical time span.

How does psychological ill health amongst veterans compare with that of the general population?

A study of community mental health data collected in 2007 (Jenkins et al., 2009) compared veterans of compulsory military service (CMS – see below) with non-veterans and concluded that they did not show any difference in behavioural, physical or mental outcomes. The exception was that the veterans were less likely to have a mental disorder. The authors state that as this was a community-based survey, it did not include those who were receiving residential or hospital care – which means that this finding should be treated with caution (Woodhead et al., 2011a). The same survey was also analysed to examine post-National Service veterans, aged 16–64 (Woodhead et al., 2011b). There was no significant difference in the psychological health of veterans and non-veterans; but the study did indicate that personnel leaving before the completion of 4 years' service may have more psychological difficulties. It also showed an increase of adverse childhood events in male veterans. As the survey did not include those in psychiatric hospitals, care homes or among the homeless it may have excluded veterans with the most serious difficulties. Iversen and colleagues (2005) comment that overall the military display better mental health than the rest of the population. This may not be surprising, as those with serious mental illness or learning disabilities would not be allowed to serve in the Armed Forces. They found that, on discharge from the Armed Forces, the cohort studied were more likely to have found employment than those seeking employment in the general population. They comment, however, that those who experienced poor mental health and left the Forces early were more likely to be unemployed after leaving. UK data on psychological comorbidity in the general and the military population is sparse (Black et al., 2004; Shevlin et al., 2008). A search of the statistics to compare the mental health of the

general population with those in the military proved problematic. The last Adult Psychiatric Morbidity Survey for England took place in 2007. Jenkins et al. (2009) comment that PTSD within the general population over the age of 16 was included in the survey for the first time. One third of those surveyed had experienced a traumatic event, and 3% screened positive for PTSD, decreasing with age. The study did not distinguish people with mental health problems who were veterans, or those who were homeless. Planned improvements in the collection of Mental Health statistics in the UK may lead to more reliable information for health service planning. The Mental Health Minimum Data Sets (MHDMS) collates returns from psychiatric hospitals, out-patients' clinics and community mental health teams on a quarterly basis (Health and Social Care Information Centre, 2013). However, interrogating the data does not reveal specific information about diagnosis (Health and Social Care Information Centre, 2014). Murrison (2010) recommended better information sharing between the NHS and military health records. GP practices are encouraged to ask patients whether they have served in the military and NHS mental health teams now ask this question as a routine part of referral information (Health and Social Care Information Centre, 2014).

Compulsory Military Service (CMS) began in 1939 and was formalised through the National Service Act 1948, which was repealed in 1960. Between January 1949 and 1963, it is estimated that 2.5 million young men in the UK completed CMS (Hickman, 2004). It has been questioned whether CMS had a long-term effect on their earning capacity and education (Buonanno, 2007). Men over the age of 18, unless in a reserved occupation or declared unfit, had to complete 18 months' CMS, increased to 2 years in 1950 because of the Korean War. Any male born since 1943 will not have been subject to CMS. It may be argued that due to CMS males born before that year would have had a common experience of the military environment and conflict. In clinical terms many within that cohort may have suffered from various psychological problems including PTSD. This common experience of military life that pervaded wider UK society changed in 1960, causing a cultural disjunction between those serving in the military and their families and those with little contact or close knowledge of the work of the Armed Forces (Strachan, 2003).

Suicide rates amongst military personnel and veterans

The increase in psychological support for service personnel was a response to concerns raised by research highlighting suicide rates among young soldiers (Kapur et al., 2009). McAllister, Greenberg and Henderson (2011) refer to the overall lower suicide rate in the military compared to the general population, with the exception of soldiers between the ages of 16 and 21, where it is 50% higher than the general population. The age range is relevant when considering that a cohort study examining national databases for suicides (Kapur et al., 2009) emphasised that overall the rates of suicide amongst veterans was lower than the general population. In the period between 1996 and 2005 statistics show that 233,803 personnel left the military, see table below. Out of this number there were 224 suicides (less than 1%). This study also demonstrated that the risk of suicide in the 16–24 years male veteran group continued to be 2–3 times greater than in the ‘civilian’ population (Kapur et al., 2009; Fossey, 2010, 2012; Windfuhr and Kapur, 2011).

Numbers and crude rates for suicide in males who left the UK Armed Forces and males serving in the Armed Forces 1996–2005 (Office for National Statistics, 2012)

Age at Death (y)	Number of Suicide Deaths	Crude Rate	Age-Specific Rate Ratio ^a (95% CI)	SMR (95% CI)
16–19	23	29.9	292.9 (185.1–441.1)	—
20–24	78	34.0	169.9 (134.0–212.7)	—
25–29	44	21.3	90.6 (65.7–121.8)	—
30–34	29	17.0	67.4 (45.1–96.9)	—
35–39	10	11.1	46.1 (22.1–84.8)	—
40–44	17	13.1	56.8 (33.1–91.1)	—
45–59	14	11.2	56.9 (31.1–95.5)	—
16–59	215	20.9	—	96.5 (84.4–110.4)

Age categories restricted to 16–59 y because no deaths in older age groups.

^aUsing the general population as the reference population. In this table age-specific rate ratios and SMR are expressed so that a figure of 100 indicates suicide risk equivalent to the risk in the general population, figures under 100 indicate reduced risk, and figures over 100 indicate elevated risk.

doi:10.1371/journal.pmed.1000026.t001

The risk of suicide was greatest in the first two years following discharge and amongst those who were in the lowest ranks whilst serving. It is not clear whether those that had committed suicide were already vulnerable due to pre-enlistment social and psychological difficulties (Kapur et al., 2009). Research has shown that the suicide risk is high amongst young men in the general population too (Windfuhr et al., 2008; Windfuhr and Kapur, 2011; Pitman et al., 2012; While et al., 2012; Office for National Statistics, 2014). It is important to consider the increased rate of suicide in the military amongst this age group

(Pinder et al., 2011; Holmes et al., 2013). One of the problems identified is that this age group were less likely to have sought help for their mental health problems (Pitman et al., 2012). This is of serious concern both in the military and the wider health care system (Prince et al., 2007; Windfuhr et al., 2008; Iversen et al., 2010; While et al., 2012; van Hoorn et al., 2013). The statistics on suicide may involve some duplication. Statistics from the general population will include suicides from amongst the Armed Forces, veterans and general communities. Since 2004, coroners in England and Wales may return a narrative verdict, a factual detailed statement of events surrounding someone's death, based on the evidence heard. It is argued that some deaths suspected of being suicide will not be recorded as such (Gunnell et al., 2012; B.S. Palmer et al., 2014). It is noted that the statistics were collected a considerable time before the report was released. The statistics are from 1996 to 2005 and the report is dated 2012; currently a different trend may be emerging.

What are the risk factors for psychological ill health amongst UK combat veterans?

The identified risk factors of psychological ill health are rank; comorbidity; reservists; childhood factors; proximity to the threat; and poor mental health prior to joining the military.

Rank

Iversen et al. (2008), in an analysis of the KCMHR cohort study, comment that lower ranks in the 'forward area' (combat zone) have a greater risk of developing PTSD than do officers. (Other studies also assert that those in the lower ranks are more at risk of developing psychological illness.) Iversen et al. (2008) question whether this may be due to elite forces being highly trained and experienced, with officers who struggle being removed from the front-line more rapidly than other ranks. The study suggests that preparation, role competence and leadership may play an important part in mitigation against the risk of developing PTSD. A view that elite forces (such as the Royal Marines, the Special Air Service, the Parachute Regiment and the Special Boat Service) may have improved post-war mental health is supported by an earlier study of an airborne troop (Hughes et al., 2005). A critique of this study (Hoge, Castro and Messer, 2004) posited that stress was measured by changes in cortisol levels: if combatants were less stressed on their

return from operations there could be a different explanation – the raised adrenaline produced when preparing for battle. The reduced adrenaline levels may be due to the relief felt at having returned safely. Hoge et al. (2004) also suggest that the self-report questionnaires may not reflect the true situation since participants may fear an adverse effect on their career. He recommends a longer-term follow-up. Other studies also assert that those in the lower ranks are more at risk of developing psychological illness.

Comorbidity

A longitudinal study investigating persistent PTSD (Rona et al., 2012) found that untreated comorbid illnesses such as depression, alcohol dependence and anxiety disorders have an adverse effect on remission from PTSD. In Section 2.3 above I make reference to various studies highlighting the need for more research on comorbidity amongst veterans. One difficulty is that the existence of comorbidity, in particular misuse of alcohol and other substances, may exclude veterans from various treatment programmes. Research has increased in this area since 2010 (Jakupcak, Tull and McDermott, 2010; Bergman, Mackay and Pell, 2014; Debell et al., 2014; McDevitt-Murphy, 2014). Debell et al. (2014) report that their systematic review of veterans with PTSD reported concurrent alcohol abuse in between 2% and 63% of cases. This wide variation in reported incidence underlines the need for consistency in recording these statistics. The average occurrence of alcoholism was above 10%. They recommend a routine alcohol screening of patients as part of the assessment for PTSD so that the necessary help can be given. Veterans with mental health or substance misuse problems may also be homeless (Dandeker et al., 2005; Fossey, 2010) and thus excluded from surveys. If the veteran is being treated for a long-term mental illness in primary or secondary care, the medical services may be unaware the person has served in the military (Murrison, 2010).

Reservists

The UK is relying on an increasing number of reservists to provide military service. There is concern that they appear to be suffering a greater percentage of psychological illness than those in the regular forces (Dandeker, Greenberg and Orme, 2011). One study (Harvey et al., 2011) highlighted the difficulty reservists have in readjusting to civilian life post-deployment. They often reported feeling unsupported by the military once they came to the end of their tour of duty. There was an increased reporting of common mental

disorder, probable PTSD, and alcohol misuse, compared with the regular army (N. Jones et al., 2011). A further study highlights that reservists are older and often hold a higher rank, but suffer more from lack of company cohesion and relationship difficulties on return home (Browne et al., 2007). Some reservists have had previous experience of serving full time in the military but the studies do not differentiate between those with prior full-time experience and those who may have been deployed before within the Reserve Force. The implications for defence policy as well as the cost to individuals and families have led to calls for further research into how reservists can be supported to adjust when they return to civilian life (Iversen et al., 2009; Iversen, Dyson and Smith, 2005). Iversen et al. (2008) report that being deployed in a role above trade and experience increases the risk of developing PTSD in veterans and reservists.

Childhood and social factors

The debate over whether individuals should be screened for psychological fitness before being allowed to serve in the Armed Forces was tested in the case that has become known as the MoD PTSD decision (McGeorge, Hacker and Wessely, 2006), a ‘class action’ between 2000 veterans (claimant) and the MoD (defendant). One aspect of this litigation was the veterans’ claim that psychological screening should have taken place. They argued that a potential recruit with an IQ lower than 80 should be automatically excluded from enlisting. Anyone with a family or personal history of mental illness or personality disorder should also be excluded from joining the Service. Others who scored positively on screening should be subject to psychiatric assessment. If this revealed a personal or family history of mental illness they should also be excluded from military service. The MoD successfully argued that screening tools were not predictively sensitive enough, though officer recruitment involves a battery of physical and psychological tests undertaken through a selection board over 3.5 days. Pre-screening psychiatric assessment for all recruits would exclude many who would not in fact break down when involved in combat. The presiding judge ruled that the MoD’s duty of care did not extend to pre-recruitment screening.

Screening has been discussed in a number of works. E. Jones et al. (2003) analyse the difficulties with screening and the problems it caused in WW2. They state that if screening is used, a distinction needs to be made about whether that screening is for aptitude or vulnerability. If someone has a negative result from the screening process this may have a

detrimental effect on their career. It may also be damaging to their sense of self and attract a psychiatric label. Jones et al. (2003) recommend that research take place to investigate these aspects of psychological screening. French et al. (2004) highlight the reluctance of military personnel to attend for a psychological interview following a self-administered screening questionnaire, pre-deployment.

Proximity to enemy and threat to one's life

Ozer et al (2003) highlighted in their meta-analysis that personal perceptions of threat to one's life showed a robust link to the development of PTSD, and Iversen et al. (2008) supported this. Both studies identified that being in a forward area (with proximity to threat) contributed to the development of PTSD. Subjective appraisals of threat remained significant in the maintenance of symptoms regardless of the objective appraisal of risk (Iversen et al., 2008; Barbour et al., 2009; Ehlers, 2010) or perceived threat to life (Ozer and Weiss, 2004).

Managing risk, stigma and help-seeking

There is an on-going campaign within the military to end the stigma associated with mental health problems (see <http://www.army.mod.uk/welfare-support/23386.aspx> [Accessed 27 April 2016]). Within the military the focus in prevention of psychological illness is often on building resilience to stress (Sareen and Belik, 2009; Bryan et al., 2012; M. Jones et al., 2012; Du Preez et al., 2012). Greenberg, Langston and Jones (2008) examined a preventative occupational stress management process that is now in place, known as Trauma Risk Management (TRiM). The UK military believe that the people best placed to notice a change in military personnel's behaviour following a potentially traumatic incident is the Chain of Command and their peers. Within most units there are TriM-trained practitioners. The two-day training equips non-medical military personnel with the skills to offer support, psycho-education and monitoring (Greenberg et al., 2011a). Following an incident affected personnel will be offered an informal interview, outcomes will be recorded, the process is repeated in 4 to 6 weeks and if they are still showing signs of psychological distress they will be directed to further help (British Army, 2014). It is emphasised that this is not psychological treatment or therapy, and the process is thought to be more acceptable to military personnel than more formal access to psychological services. Trained members of the affected person's unit deliver TRiM as a

standard part of preparation for action. It is also repeated following serious incidents, such as serious injuries, or loss of life. The training has been evaluated in one trial using a control group (Greenberg et al., 2011b). This showed participant satisfaction with the process, but was unable to draw conclusions as to whether it reduced the risk of PTSD. An interesting point raised in that study is that personnel who had experienced TRiM thought it reduced the stigma associated with mental health difficulties. However, some people expressed concern about confidentiality and suitability of some individuals to undertake the role of a TRiM practitioner. Some units did not have access to TRiM as it is influenced by the Commanding Officer's view of psychological health. An earlier study (Iversen et al., 2010) examined barriers to care including stigma, suggesting that TRiM may help to counteract stigma, but that there is not enough evidence to support this. TRiM is now becoming more widely used, but it may be that it is too early to produce any reliable statistics. In a further study (Frappell-Cooke et al., 2010), an evaluation was undertaken of two units of Royal Marines deployed to Afghanistan. Both groups suffered serious traumatic incidents and used TRiM. The unit more experienced in the use of TRiM showed greater benefit, but both groups reported less psychological distress following the implementation of TRiM. The Military Mental Health Service evinces a commitment to devise strategies to manage psychological risk in their personnel (Iversen et al., 2010; Greenberg and Jones, 2011).

Appendix 3 Study recruitment poster



Coming Soon:
Dramatherapy Group for Veterans
Linda Winn, Veterans' Therapist is holding a free Dramatherapy
Group for 8 weeks:
Thursday 1pm-3.30pm
Royal British Legion, [xxxxxxxxxxx]
This is part of her research through Anglia Ruskin University.
Want to find out more?
There will be a briefing:
May 29th at the above venue at 1pm
A DVD explaining the project is also available
Please contact Linda at the Royal British Legion above
Or
email:linda.winn@student.anglia.ac.uk

Attendance at the briefing does not commit you to participate

Appendix 4 Specimen copies of outcome measures

Outcome measures

All scales are free to use. Permission has to be sought. Clinicians should be trained in how to use and interpret the measures. For this reason I have omitted the scoring sheets.



Site ID	<input type="text"/>	<input type="text"/>	Male	<input type="checkbox"/>
letters only	<input type="text"/>	numbers only	<input type="text"/>	Female
Client ID	<input type="text"/>	<input type="text"/>	Age	<input type="text"/>
Therapist ID	<input type="text"/>	numbers only (1)	<input type="text"/>	Stage Completed
<input type="text"/>	<input type="text"/>	numbers only (2)	<input type="text"/>	S Screening
Sub codes	<input type="text"/>	<input type="text"/>	<input type="text"/>	R Referral
D D M M Y Y Y Y	<input type="text"/>	<input type="text"/>	<input type="text"/>	A Assessment
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	F First Therapy Session
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	P Pre-therapy (unspecified)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	D During Therapy
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	L Last Therapy Session
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	X Follow up 1
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Y Follow up 2
Date form given	<input type="text"/>	<input type="text"/>	<input type="text"/>	Episode
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

IMPORTANT - PLEASE READ THIS FIRST

This form has 34 statements about how you have been OVER THE LAST WEEK.

Please read each statement and think how often you felt that way last week.

Then tick the box which is closest to this.

Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week

	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
1 I have felt terribly alone and isolated	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
2 I have felt tense, anxious or nervous	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
3 I have felt I have someone to turn to for support when needed	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
4 I have felt OK about myself	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> W
5 I have felt totally lacking in energy and enthusiasm	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
6 I have been physically violent to others	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
7 I have felt able to cope when things go wrong	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
8 I have been troubled by aches, pains or other physical problems	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
9 I have thought of hurting myself	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
10 Talking to people has felt too much for me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
11 Tension and anxiety have prevented me doing important things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
12 I have been happy with the things I have done	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
13 I have been disturbed by unwanted thoughts and feelings	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
14 I have felt like crying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> W

Please turn over

Over the last week

	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
15 I have felt panic or terror	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
16 I made plans to end my life	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
17 I have felt overwhelmed by my problems	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> W
18 I have had difficulty getting to sleep or staying asleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
19 I have felt warmth or affection for someone	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
20 My problems have been impossible to put to one side	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
21 I have been able to do most things I needed to	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
22 I have threatened or intimidated another person	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
23 I have felt despairing or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
24 I have thought it would be better if I were dead	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
25 I have felt criticised by other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
26 I have thought I have no friends	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
27 I have felt unhappy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
28 Unwanted images or memories have been distressing me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
29 I have been irritable when with other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
30 I have thought I am to blame for my problems and difficulties	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
31 I have felt optimistic about my future	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> W
32 I have achieved the things I wanted to	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
33 I have felt humiliated or shamed by other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
34 I have hurt myself physically or taken dangerous risks with my health	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

Total Scores


<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	→ <input type="text"/>	→ <input type="text"/>
----------------------	----------------------	----------------------	----------------------	------------------------	------------------------

Mean Scores

(Total score for each dimension divided by number of items completed in that dimension)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(W)	(P)	(F)	(R)	All items	All minus R

151/05

 CORE - 10	Site ID <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	Male <input type="checkbox"/>
	Client ID letters only: <input type="text"/> <input type="text"/> numbers only: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Age	Female <input type="checkbox"/>
	Therapist ID <input type="text"/> <input type="text"/> <input type="text"/>	Stage Completed S Screening R Referral A Assessment F First Therapy Session P Pre-therapy (unspecified) D During Therapy L Last Therapy Session X Follow up 1 Y Follow up 2	Stage <input type="text"/>
	Sub codes D D M M Y Y Y Y <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Episode <input type="text"/>	
	Date form given <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

IMPORTANT – PLEASE READ THIS FIRST

This form has 10 statements about how you have been OVER THE LAST WEEK.
 Please read each statement and think how often you felt that way last week.
 Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week

	Not at all	Only Occasionally	Sometimes	Often	Most or all the time
1 I have felt tense, anxious or nervous	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2 I have felt I have someone to turn to for support when needed	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
3 I have felt able to cope when things go wrong	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
4 Talking to people has felt too much for me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5 I have felt panic or terror	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6 I made plans to end my life	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7 I have had difficulty getting to sleep or staying asleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8 I have felt despairing or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
9 I have felt unhappy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
10 Unwanted images or memories have been distressing me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

Total (Clinical Score*)

* **Procedure:** Add together the item scores, then divide by the number of questions completed to get the mean score, then multiply by 10 to get the Clinical Score.

Quick method for the CORE-10 (if all items completed): Add together the item scores to get the Clinical Score.

03129

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

SWEMWBS

Below are some statements about feelings and thoughts.

Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5

Short Warwick–Edinburgh Mental Well-being Scale (SWEMWBS)
 © NHS Health Scotland, University of Warwick and University of Edinburgh,
 2007, all rights reserved.

PTSD CheckList – Military Version (PCL-M)

Patient's Name: _____ Date: _____

SSN: _____ Service: _____ Rank: _____

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful military experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem in the last month.

No.	Problem or Complaint:	Frequency:				
		Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing memories, thoughts, or images of a stressful military experience?					
2.	Repeated, disturbing dreams of a stressful military experience?					
3.	Suddenly acting or feeling as if a stressful military experience were happening again (as if you were reliving it)?					
4.	Feeling very upset when something reminded you of a stressful military experience?					
5.	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful military experience?					
6.	Avoid thinking about or talking about a stressful military experience or avoid having feelings related to it?					
7.	Avoid activities or talking about a stressful military experience or avoid having feelings related to it?					
8.	Trouble remembering important parts of a stressful military experience?					
9.	Loss of interest in things that you used to enjoy?					
10.	Feeling distant or cut off from other people?					
11.	Feeling emotionally numb or being unable to have loving feelings for those close to you?					
12.	Feeling as if your future will somehow be cut short?					
13.	Trouble falling or staying asleep?					
14.	Feeling irritable or having angry outbursts?					
15.	Having difficulty concentrating?					
16.	Being "super alert" or watchful on guard?					
17.	Feeling jumpy or easily startled?					

PCL-M for DSM-IV (11/1/94)

Weathers, F.W., Huska, J.A., Keane, T.M. PCL-M for DSM-IV. Boston; National Center for PTSD – Behavioral Science Division, 1991.

This is a Government document in the public domain.

Appendix 5 Anglia Ruskin University Research Ethics Committee Permission

27th November 2012
SID Number: 0176290/2



Anglia Ruskin
University

Cambridge & Chelmsford

Chelmsford Campus
Bishop Hall Lane
Chelmsford
CM1 1SQ

T: 0845 271 3333
Int: +44 (0)1245 493131
www.anglia.ac.uk

Ms Linda Winn
Green View
Henwood, Liskeard
Cornwall
PL14 5BP

Dept: Academic Office
Tel No: 0845 196 4917 (Direct dial)
Tel: No: +44 (0)1245 493131 ext 4917 (International dial)
Fax: +44 (0)1245 684867
Email: sara.donner-langstone@anglia.ac.uk
Ref:

Dear Linda,

Approval of Research Proposal

I refer to my letter of 12th November 2010 advising that your research proposal had been approved subject to you gaining ethics approval.

I am pleased to confirm that the Arts, Law and Social Sciences Faculty Research Degrees Sub Committee noted, at its recent meeting, that ethics approval had now been granted and that you had therefore met this condition.

Yours sincerely

Sara Donner-Langstone
Acting Secretary, Arts, Law and Social Sciences Faculty Research Degrees Sub Committee

c.c:

1st Supervisor
Dr Ditty Dokter

2nd Supervisor
Prof Helen Odell-Miller

Faculty Director of Research
Prof Eugene Giddens

Faculty Director of Research
Students
Prof Sarah Brown

Faculty Research Administrator
Helen Jones

[Research Proposal Conditions]



Appendix 6 Sample Information and Consent Sheets

Research Project:

The Theatre of War, the Drama of Life.

Participant Information Sheet



Linda Winn, M.Phil, MCGI, R.N., Dramatherapist, Reg.
Psychotherapy Supervisor, Accredited EMDR Practitioner

Thank you for reading this information sheet. It is really important that before you make any decisions about taking part in my study you understand why the research is being done and what you will be asked to do. Reading this information sheet will help you but you can also ask others, including myself for more information before you make a final decision.

This sheet is divided into 2 sections; part 1 contains general information about the research and will give you an idea about what you will have to do if you agree to take part. If you are still interested in learning more about the project after reading part 1 you can read part 2, which goes into more detail about what is involved.

PART 1

What is the research and who is doing it?

I am inviting you to take part in a research project I am carrying out as part of my part-time postgraduate doctoral research at Anglia Ruskin University. I have been involved in working with veterans with psychological difficulties for over 30 years. I have decided to try and find out about if dramatherapy can help veterans adjust to life outside of the services. I am doing this research as part of my doctoral studies. It is building on earlier research that I have carried out using dramatherapy to treat veterans.

What is the study about?

Service personnel exposed to the trauma of war may experience severe psychological difficulties when adjusting to life as a civilian.

This research examines if performance methods applied in Dramatherapy contribute to improved mental health in veterans.

Whilst in the military most veterans displayed physical and psychological strength. They also had to learn new roles. These aspects may be re-engaged to overcome current difficulties.

The aims of the research are to determine whether Dramatherapy restores or builds self-esteem in veterans suffering from the effects of traumatic experiences. It will also evaluate whether skills practised by veterans during dramatherapy can assist reintegration into civilian life.

Who will take part as participants?

There will be 3-6 participants in the study. They will receive individual sessions of dramatherapy:

The participants will be drawn from combat veterans who are recovering from trauma and adjusting to life as civilians. The eight sessions will be 90 minutes long and occur over a 12 week period. You will be invited to comment on whether you found the sessions helpful through some interviews and questionnaires.

Why is it being done?

Some research that has been carried out using dramatherapy with Combat Veterans points to improvement in well-being. The research aims to examine and build on these findings.

Veterans often report an increased sense of well-being when engaged in an artistic process. Various studies reflect good effects. These studies have not been considered structured enough to include dramatherapy as a recommended treatment for assisting veterans in the recovery from trauma.

The research will give a voice to the study participants about what is important to them as they seek a road to recovery.

Why have you been invited to take part in this project?

You have expressed an interest as a result of the poster information displayed at the veterans' trauma support group or through discussion with your keyworker.

Do I have to take part?

No! It is completely your decision and no one will mind if you decide not to take part - you do not have to give a reason. Keyworkers will not tell me that they have given you this information unless you decide to take part.

It is my own research, which is funded by me and overseen by Anglia Ruskin University. Therefore no one at the support groups or within any organisations is relying on you to take part, and whether you say yes or no; the care you receive will not change in any way.

What will I have to do if I say yes?

I will meet with you to explain the research further and to answer any questions you may have concerning the research. I will spend some time giving you more details about the research and what will happen to the information you give me. Then, before we begin the first session, I will ask you to sign a consent form to say you are still happy to take part. I will give you a copy of this consent form to keep. **Please be aware that at this stage or at any time, you can still withdraw from the project without giving a reason.**

All interviews and questionnaires will remain confidential, and no personal details will be given to anyone. All names will be changed before any findings are released.

Is there anything for me to be worried about if I take part?

I would like you to think carefully before agreeing to take part in this research. When the sessions take place, I am not going to be looking for 'right' or 'wrong' answers and I hope that our sessions will feel relaxed and fun. The sessions will not be about re-enacting trauma. However there is a chance that sometimes we might get talking about things which are difficult for you, and could make you feel upset. You do not have to participate and if you feel upset you will be given support and the opportunity to take a break. It is not a problem, however, if you do get upset while we are together, and I will seek to remind you that it is a normal reaction to traumatic memories.

What are the possible benefits of taking part?

Some dramatherapy participants have said that taking part in research has been a positive experience. They have said it felt good for their views and contributions to be listened to. They have felt more confident. However I am not able to promise that this will be the case for you, or that you will benefit directly from taking part. However it is hoped that your help with this research will provide information, which will benefit other veterans in the future.

What do I do next?

If you are happy to take part in the research, please complete the forms enclosed in this pack. There is an addressed post-paid return envelope. I will then send you further information about the briefing session and venue.

If you do not want to be involved in the research, you don't have to do anything with the reply slip.

Thanks for reading so far. If you are still interested, please now read part 2 which gives you more detail.

PART 2

What will happen when the research project comes to an end?

When the study has finished I will look at all the information I have gained from the individual sessions, discussions and questionnaires from you and other veterans. I will then write a report in every day language about the findings and I can send you a copy. I will submit a piece of academic work based on what I find out for my Ph.D., and I will also use some of the information to write articles to be published in academic journals and to give presentations to clinical staff and other researchers. These findings will be anonymized.

What happens if there is a problem or something goes wrong?

If you feel unhappy about anything to do with the research, I will be happy to talk to you about your concerns at any time, during business hours. You can also stop taking part at any time; this will not affect your planned care or access to health services.

What can I do if I am unhappy about something to do with the study?

In the unlikely event that you are harmed by taking part in this research, there are no special compensation arrangements. If however you are harmed as a result of someone's negligence, then you do have grounds for legal action, but you may have to pay for it.

If you have any complaints or concerns, please contact myself, Linda on a number at the end of this information sheet. If you are not happy with the response you receive, then you can contact my research supervisor Dr Ditty Dokter: ditty.dokter@anglia.ac.uk

I want to make a complaint about the research

Please send details of the concern or complaint to Jennifer Powell, Board Executive Assistant in The Office of the Secretary and Clerk, 3rd Floor, Tindal Building, Chelmsford Campus, CM1 1SQ. You should use the generic email address below i.e. complaints@anglia.ac.uk

Emails will be acknowledged immediately and a response will be given within five working days.

Letters will be responded to within five working days of receipt.

Email: complaints@anglia.ac.uk

Postal address: Office of the Secretary and Clerk, Anglia Ruskin University, Bishop Hall Lane, Chelmsford, Essex, CM1 1SQ

Who will know that I have taken part?

If you are a patient your keyworker may be aware that you have participated; although what you choose to tell me during the research will remain private. The only time I will take action and speak to another appropriate person about you, is if I am concerned for your safety or the safety of another person. An example would be if you were very distressed and talked about feeling suicidal. I would tell you about my concerns before I spoke to anyone else, and my only reasons for doing this would be to help you or another person.

Any notes or tapes will have your name and address removed so you cannot be recognised from them. All material relating to the research that is kept on a computer will be password protected; only I will know the password. All personal information which relates to participants such as addresses and signed consent forms, will be kept locked away securely

in my office. Only I will have access to the information. The information collected during the project will be destroyed after 3 years. The audio-tapes will be erased once any content has been put into writing and you have had the opportunity to confirm that the written record (transcription) is accurate. If you wish to make amendments to the written record, where it is not an accurate record, or you feel it gives too much detail, you will be able to do so.

Often when researchers write up their work, they like to include quotes to show what people have told them. If I want to write about something you had said to me in any future publications no one will know it is you because I will refer to you using a false name. I will not refer to the sessions by their geographical area.

What about safety?

If I had concern that you were posing a serious risk of harm to yourself or others in the first instance I would discuss with you the best way to proceed. Preferably with your agreement your keyworker or sponsor would be informed of the situation and a plan agreed. In an exceptional circumstance it may not be possible to have that conversation with you first if to do so may increase the risk to yourself or others.

Who is organising and funding the research?

I am the only person working on this research project. I do have two experienced supervisors at Anglia Ruskin University, who are available to advise and support me. I will work closely with them and we will talk about the study, but they will not know who you are or have access to any of your personal details, such as your address.

I am funding the research.

Who has reviewed the project and said it is okay?

Before any research goes ahead it is checked by an Ethics Committee. They make sure that the research is okay to do and that participants will be treated with care and respect. The study has been checked and approved by the Faculty Research Ethics Committee. Throughout the years that I will be working on the research the University can ask to see my work and will monitor my progress.

Do you have any qualifications to do this work?

I am a Dramatherapist, registered with the Health and Care Professions Council. I have to abide by their Standards of Practice and be competent within this area of practice. More information is available at:

<http://www.hpc.uk.org/aboutregistration/standards/standardsofconductperformanceandethics/index.asp>

I am also a Registered Nurse and expected to abide by the Nursing and Midwifery Council Code of Conduct: <http://www.nmc-uk.org/Nurses-and-midwives/The-code>

What happens if I change my mind about taking part?

You are free to withdraw from the research at any time. You can do this by returning the slip in the stamped addressed envelope, by email or telephone or asking your keyworker or sponsor to inform me. You do not have to give a reason. Your access to treatment will not be affected by your decision.

Who can I contact for further information about taking part?

If you would like to contact me to discuss anything to do with this research then please do not hesitate to do so

Many thanks for reading this – if you have any questions please ask.

I can be contacted on [contact details given]

Participant Consent Form

NAME OF PARTICIPANT:

Title of the study: The Theatre of War – the Drama of Life

Main investigator and contact details: Linda Winn, Linda.Winn@student.anglia.ac.uk

Linda Winn Veterans' Therapist [address details supplied]

1. I have read the Participant Information Sheet, which is attached to this form.
I understand what my role will be in this research, and all my question have been answered to my satisfaction.
2. I have been provided with a copy of this form and the Participant Information Sheet.
3. I understand that taking part is voluntary and that I am free to withdraw at any time.
I DO NOT have to give a reason and my legal rights and the support I receive from my keyworker, if any, will NOT be affected. If I want to stop taking part in the research I can contact Linda directly or speak to my keyworker. If I prefer I can send the withdrawal from study form to Linda.
4. I understand that any information I give will be used for research purposes only, including research publications and reports. I give my permission for my anonymised contributions to be used for research-related work and presentations.
5. I understand and am happy with how the researcher will protect my right to confidentiality and anonymity.
6. I understand that everything that is stated here applies to my entire involvement with this study and on each occasion I am interviewed.

7. I give my permission to be contacted again within a three-year period.

8. I agree to take part in the above research project.

Data Protection: I agree to the University processing anonymised personal data which I have supplied. I agree to the processing of such data for any purposes connected with the Research Study as outlined to me.

Name of participant (print).....Signed.....Date...

YOU WILL BE GIVEN A COPY OF THIS FORM TO KEEP

If you wish to withdraw from the research, please complete the form below and return to the main investigator named above, alternatively you can inform your keyworker.

Title of Study: The Theatre of War – The Drama of Life

I WISH TO WITHDRAW FROM THIS STUDY

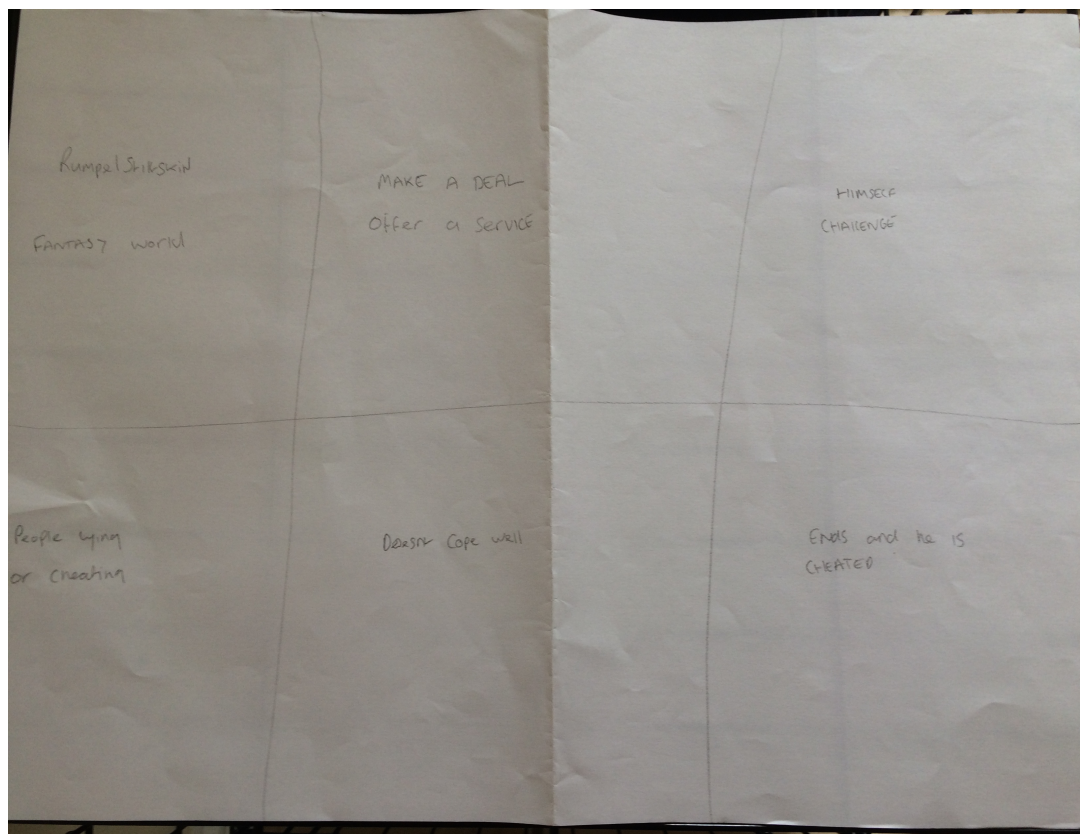
Signed: _____ Date: _____

Appendix 7 Copies of Alan's, Jack's and Chris's 6PSM

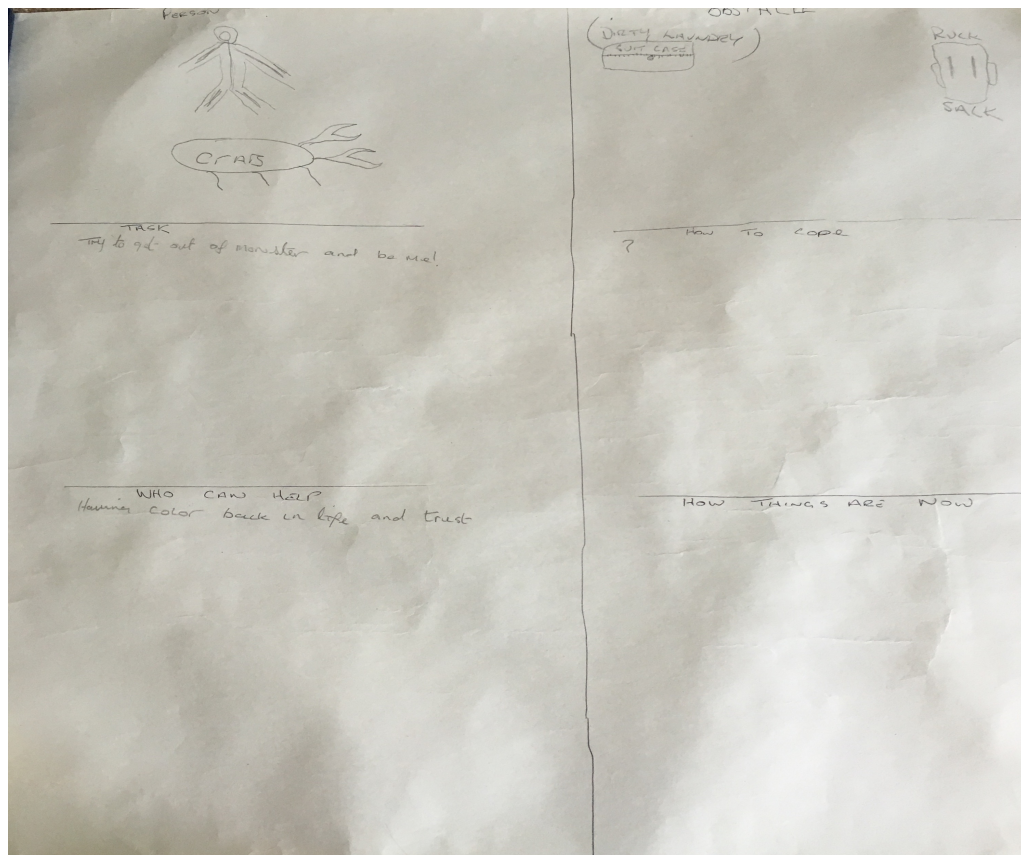
Alan's 6PSM



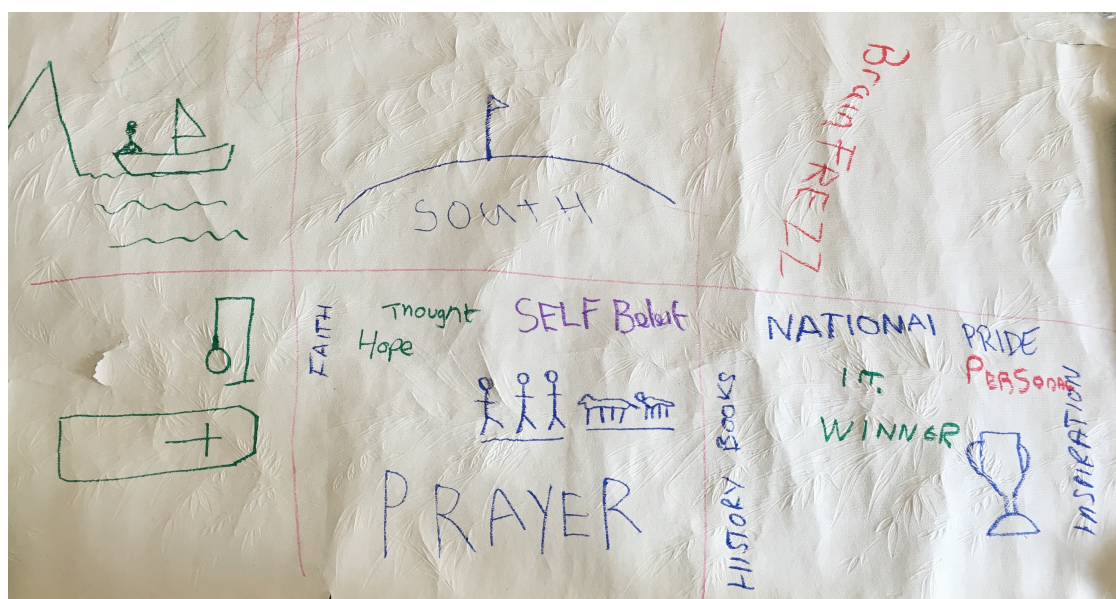
Jack's 6PSM



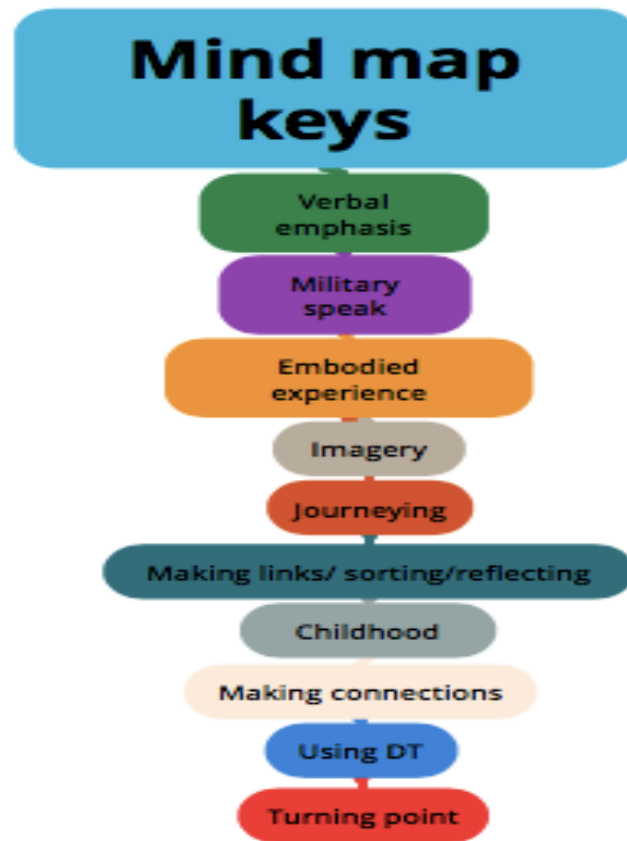
Chris's 6PSM



Group 6PSM



Appendix 8 Mindmaps, colour coding and emerging themes samples





Jack Emerging Themes

1

Jack. Emerging themes

CLUSTER	Session 1	Session 2	Session 3	Session 4	Session 5	Emerging theme
Dramatherapy	Creative-Strong imagery- Good recall Rhythm of story	Finding voice - dialogue, reframing, commingle (hour-glass) Problem-solving, New light, His[s]tory re-scripting 348, metaphor, moving on, distancing, character, images	Distancing, Metaphor, TM challenges in good way - calm 779, Planning/ rehearsal[-ve terrified of change] Embodiment 532 Storying no longer judgemental 618	PTG _ belief system shattered dt restructures differently 11,18 Reframes 14 New light / angles 13, Audience perspective, take lead		
Developmental	Insecure attachment, low self-esteem, childhood cultural issues	Disorganised attachment Beaten dog - however nice can't be rehomed-ruined	Childhood ambivalence 856		Rage	
Loss	Breaking	Destructive impulses		Flip if feel weak/ threatened 804, Physical injury/poor self-image642 restorying 2	Loss of role Suicides, external event LR murder, enough is enough - Athena 43	
Sense-making Cultural	Thinking	Solving puzzle 46, building bridges 615-616,	Linking between sessions/ recall 550	Change scary, what if no need to fight 17,21	Odyssey-problem-solving, -ve is risk over-identification 6, still journeying, nothing magicalto help 42	
Hope		Stuck- but HOPE, turning point	Hope		Choices 25	

Jack Emerging Themes

2

CLUSTER	Session 1	Session 2	Session 3	Session 4	Session 5	Emerging theme
Military Influence		Broken 31, 135, Flashpoint embodied aggression, numb 220, Injustice, rules, punishment	Shame/guilt. no empathy, pity or guilt 287/ foxhole hide 532.shattered dreams, break you and everything 306, in military if something broken gets fixed 136. Need a secure base to fly 119	Strength 19,	Gallantry 26	
Spiritual					Valhalla 7, sacrifice to rescue 1,5,16 Karma	
Personal	Strong opinions, Personal constructs					

Group Emerging Themes

1

CLUSTER	Session 6 Part 1/ Part 2/	Session 7	Session 8
<p><i>Colour Key:</i></p> <ul style="list-style-type: none"> - Alan - Jack - Chris - Group <p>Dramatherapy</p>	<p>All relate to playing Odysseus (O) 1/284</p> <p>Beggar or King 1/316</p> <p>Transition at end v important - de-role 2/230-232</p> <p>All relate sneaking in back door 1/284. Text triggers traumatic memory difficult to find safe place 1/30</p> <p>Didn't sneak in- assertive, pride 2/58-59</p> <p>Re O text PTSD talking 1/109. Playing, in role, fluent precise 2/21-117</p> <p>Good - delved beneath surface 2/106.</p> <p>Under-distanced - take months of playing role to realise it's not real 1/271 Can see point of DT 1/308, Sums up process gets pulled in 1/326. Enjoys listening 1/178. Under defences get tripped up but ok now 2/172. Problem solving, distancing helps 2/205-206</p>	<p>Very, very challenging 22-23</p> <p>Love it energised 55-58</p> <p>Enjoying creativity of DT though 'really, really hard' 346 Looks too deep over stimulated 34-36. DT's opened the door, 55</p> <p>TMOC Reframing - acknowledging positive skills 974-976</p> <p>Concentrating gives respite from intrusive thoughts 342-345</p> <p>Concrete easier - not room in mind for abstract - 'I like to keep it simple' 468-469</p> <p>Enjoying creative potential 550-553</p> <p>TMOC Takes on director role - problem-solving 806</p> <p>Safe place - seeks grounding in familiar things 859-863</p> <p>Rehearses - walks through model 'parts I like'- reinforcing +ve 915-920</p> <p>Does get pretty distressing but it's good 53 Ok to listen not take part as absorb parts 27-28</p> <p>Creative Poem he shares projects on to O</p> <p>Difficult all feels grey to me 539</p>	<p>DT importance/ empowerment of space to say 'stop' 330-355.</p> <p>Feel more braver about saying things now than I did before. we are all of the same cloth...we just do it differently. 318-326</p> <p>I can say these things but copying these things, that's hard 458-459</p> <p>Didn't think DT would do anything for me but have thoroughly enjoyed it because it is not what I thought it would be 525-527</p> <p>DT Sessions are easily recalled 'we actually remember what we get from it, that's the thing. And if it's written down that will help as well 503-506</p> <p>To be honest, this is the best therapy I've had. I've really enjoyed this 519 - creative/ learning/ reframing</p>

Interview Prompt

How did you feel about the session?

Are there any aspects you would like to comment on?

Was there anything particular about the experience of the dramatherapy that might be useful to other veterans?

Was there anything about the session you think may be unhelpful for other veterans?

Were the difficulties related to the methods?

What could have helped you either in the dramatherapy or some other therapy?

Would another form of therapy have been better?

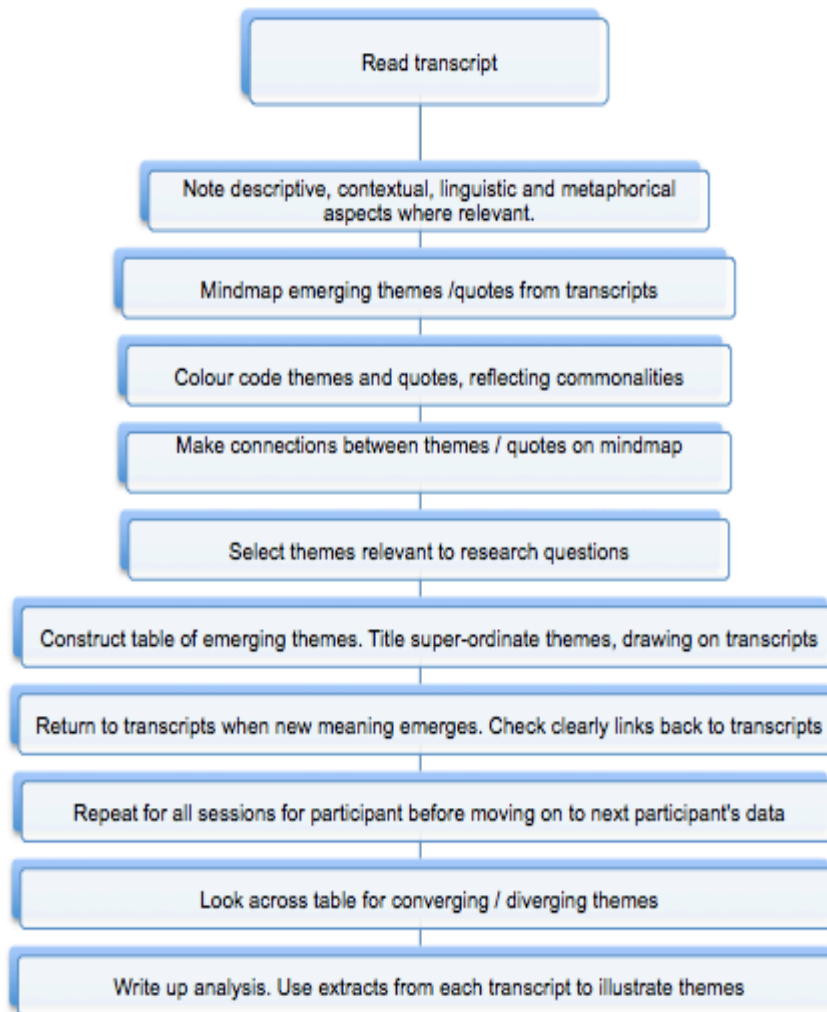
What could have helped you at that time?

How much time during sessions did you use the method?

Have you any comments on the particular dramatherapy methods we used?

Is there anything else you would like to comment on?

The excerpts above demonstrate how the themes, relevant to my research questions, were sorted into clusters using the mindmaps. These were then inserted into the tables for individuals. Looking across the columns, I was then able to identify emerging themes.



Flow chart of IPA process followed

Appendix 9 Sample transcript excerpt from an IPA analysis

22 thought oh I how's this gonna go then, I 'd never
 23 listened to a book before
 24 L, Oh right
 25 J. I thought how the story started – it was like I couldn't
 26 work out which bit was first – it starts with the god
 27 talking, he's already planned his death, the giant
 28 Cyclops and I was like "have I missed a bit here or"
 29 L, Right, yeah
 30 J. I kinda worked it out and once it got going, it goes
 31 back into the story, no but I enjoyed it, it made me look
 32 at a lot of Greek mythology and that as well – I looked
 33 at loads of stuff. But it was um, I enjoyed it.
 34 L, So was there any bits when you were looking at
 35 other mythology that leapt out to you?
 36 J. Yeah, um I wanna look at Jason and the Argonauts
 37 because the film only tells half the story which is and
 38 then it got weird where the women killed his children to
 39 spite him and he left so, he's um in, in the Divine
 40 comedy he's in hell as well and I couldn't understand
 41 why he was there, so I looked into it again and like I
 42 didn't know, the Argonauts, it was called the Argonauts
 43 and the Argonauts was a ship, and it was just a name,

Appendix 10 Personal communication from Jonathan A. Smith, 4th April 2015

Hi Linda

It depends on how you are looking at the live sessions. If you feel there is data there which, along with the post-session reflections, helps you get at the participant's experience then IPA is suitable. If however you were seeing the session through a different lens, for example, looking at the interactional properties of the therapeutic encounter then you would need to use a different method for this part of the analysis- it could be framework analysis or another observational methodology. So it is fine to use IPA as a stand-alone methodology with one type of data or, where it works, with different types of data. It is also fine to combine IPA with a different qualitative method in one study where the two methods look at different things and then come together in a synthesis. This is consonant with a pluralist qualitative approach (see writings of Nollaig Frost on this). Some refs you may find useful:

Smith, J.A., Dancyger, C., Jacobs, C., Wallace, M. and Michie, S., 2011. The development of a methodology for examining the process of family communication of genetic test results. *Journal of Genetic Counselling*, 20, 23–34.

Dallos, R., 2012. Observational methods. In: G. Breakwell et al., eds, *Research methods in psychology*. 4th ed. London: Sage.

Appendix 11 IPA Audit Report



Linda Winn: IPA quality audit – report update

Audit review: The original audit (dated 10th May) was reviewed in a one-to-one meeting between LW and EH on 29th June 2016. Only minor clarifications were needed: further elaboration of comments in the ‘Description of analysis’ section from EH, and for LW to explain that ‘Billy’ was the same participant as ‘Jack’ (he had changed his pseudonym part way through the study). The thematic clustering poster previously provided therefore referred to the same analytic trail as the other materials. What follows is the original audit text with section ‘*iii. Thematic clustering poster*’ adjusted accordingly. In addition, section ‘*v. Linking excerpts back to original transcripts*’ has been omitted as the non-matching references were identified as due to differing transcript versions and this had been resolved by LW.

Agreed audit structure: To focus on tracing the analytic process through each stage for one participant, ‘Jack’, using materials provided, and to produce a report of approximately one side of A4. Specific phases requested:

- i. *Read the transcript pertaining to one therapy-plus-interview session.*
- ii. *Examine mind map for selected session.*
- iii. *Examine thematic clustering on relevant poster.*
- iv. *Review analysis presented in Ch 5 for Jack only.*
- v. *Check that transcript excerpts for Jack can be tied back to the relevant transcripts.*

The audit process has followed the above structure, with the exception of examining the

thematic clustering poster, for which 'Jack's' material was not provided. General comments based on the clustering posters provided have been included. This report focuses on the transparency of the analytic process at each phase, clarity of connection between phases, and the clarity of the IPA theme accounts, drawing on additional material (Methodology Chapter and Chapter 4) where appropriate. The report is arranged in sections reflecting each phase of the audit, as listed above.

i. Transcript (Jack, session 3)

The transcript is clearly presented and lines enumerated. Analytic annotations by the researcher are at the descriptive level with linguistic or more interpretative points .

ii. Mind map (Jack, session 3)

Items on the mind map are direct quotes drawn from the transcript and the researcher's annotations, and are accurately line-referenced (ten randomly selected items were checked against the transcript line numbers and all found to be accurate). From the materials provided it is not clear what the role of the mind map was in the analytic process (e.g., how were the colour coded categories derived and what is their purpose, what do the links between items denote). It may be helpful to clarify these points if not already included elsewhere in the thesis.

iii. Thematic clustering poster (Jack)

One observation regarding linkage between analytic stages is that it is not clear how the colour coded categories from the mind maps fed into the clustering/analysis process (if at all). The items on Jack's posters have the feel of more developed thematic codes but there is no hierarchical structure evident in these examples. It may be useful to include material showing how the hierarchical final thematic structure reported in Ch 5 was developed from the clusters.

iv. Chapter 5 interpretative thematic analysis (theme diagrams plus Jack's sections)

Theme diagrams (p.12). The first diagram clearly shows the thematic structure presented in the full IPA section. It is not clear how the clusters in the second diagram relate to the analysis (as only some of the themes are presented) and what the links between the items indicate. Adding more detail to the figure legends would give helpful clarification. It may be

worth considering omitting the second diagram unless the emergent themes/clusters are important and discussed elsewhere.

Description of analysis. The description of the analysis (Ch 5, p.1) and methodology (Methodology Chapter) give the impression that a case study approach has been used, whereas the analysis combines all three participants' experiences into one overarching thematic structure. For consistency, it may be worth adjusting the description slightly to make it clear that it is a group-level analysis with the voice of each 'case' presented for each theme. More detail on the precise phases of the analysis, how they connect with each other and how the case-level analyses were combined into the overarching thematic structure would make the analytic process more transparent for examination/future auditing.

Theme titles. These are generally evocative but some may benefit from a little more detail to be self-explanatory (for example, what is '*Preparation*' referring to?). This would be especially helpful with the master themes, because the quotes used as titles do not alone give a clear indication of what the content refers to for those unfamiliar with the texts.

Interpretative phenomenological analysis (individual sessions; Jack). The order of theme presentation is logical and clear. It may be useful to include a brief account of the decision to present the individual and group sessions separately, as the same themes are present in both. If feasible within space constraints, it would benefit clarity throughout the analysis to include an overview at the start of each master and sub-theme to provide a sense of what the theme is 'about'. Likewise, making brief but explicit links between the master and sub themes in the analytic text would improve integration of the analysis as a whole. Note that under the '*Coming home (to self)...*' master theme the '*Preparation*' theme appears twice on consecutive pages – query if this is as intended. The relevance of analytic work to the theme title is not always clear from the limited perspective of an auditor; see '*Coming home...*' initial section, '*Spiritual*', '*Cultural*' themes for examples of where this would be clearer. Themes vary significantly in length from a couple of paragraphs to two pages; it may be helpful to consider developing the shortest themes more fully if the evidence supports this, to achieve greater balance (e.g., '*Reconnaissance*', '*Preparation*'). Overall, the excerpts presented as evidence give a good feel for Jack's 'voice' and experiences, and in appropriate detail.

Emily Hammond, BSc (Hons.), MSc, MBPSSs.

South West Regional Group Coordinator, Interpretative Phenomenological Analysis

Network.

10th August 2016

Appendix 12 Participants' Prose and Poems based on the Odyssey text

The writings are replicated as written by the participants.

Alan's prose:

Many years ago I joined Her Majesty's Armed Forces. I did well in training. I enjoyed it immensely. I fought many battles and conflicts over the years and lost a lot of good friends and comrades. The wars I fought were in a variety of places. The jungles and the deserts. Also in my case the great concrete dirty urban area of large cities. Although I'm always busy I try to keep my life always cheerful with colours and wild things I missed. My time, for much of the time I had to be quiet. I also missed the sound of running water. Those two things are now so very important to me. If active service was troubling then the journey home's more so. I went home once to pick my son up from school and I was told they didn't know me, I was nine months away from home and I knew they didn't know me and I had to be escorted to see him. When he eventually saw me and said 'dad, thank you for coming home' I could have cried. So many good experiences turned bad for me, every day things worry me. Turn that corner 'who is he?' 'Where is he from?' Perhaps the best warrior is the one that dies on the battlefield. His body and his mind is laid to rest. To me, I found the way home to my family and friends and they have kindly cared for me. I feel with them I am safe. I have got to do a bit more travelling to find that inner peace and security and safety that I require.

© author also known as (aka) Alan. All rights reserved.

The Twisted Oak - Chris

We are like the twisted oak!
Twisted and knotted up!
But we stand tall and proved
In Battle we stand together and tall!!
In life we stand alone and fall!!
But maybe we have found a place at last where life don't go so fast?
And once again we can stand together in battle and maybe
Just maybe this one we can win forever!!
This time we can see who or what the enemy is
And this time it's not a bomb or a bullet when he hear the
'BANG'
It's the sound of the army, Airforce, Navy, Marines and the rest
of the 'GANG'!
Joining together one last time to fight the battle of all battles
Here we stand twisted, knotted, but tall.
Can we win we ask as we look at each other
Then one by one each group marches forward into the fight!
Will we win – Yes I think we might.

© by author aka Chris. All rights reserved.

Chris Poem 2

This story I've written is about Odysseus.

I see him as the weary traveller.

Still lost in his world.

The world that created him.

The world that made him.

Those who call themselves Gods.

The top brass in the army, the sods!

Think they are the gods.

They built up for their fun!

Trained to carry a gun or any weapon.

To kill his foe!!

At times, who is his foe.

He asks himself?

After all, he is a boy inside a man.

Inside man!!

Will he make it back home.

Or will he be forever alone?

The agony inside my head

I awake upon the strangest shore.

I have this feeling, I have been here before.

Then I realise I am home.

But sad to find I'm all alone

A Goddess guides me to my door.

I have dreams of this, so many times before.

The door opens wide and I see my wife.

I hope I can continue, where I left my life.

I lay in bed thinking of the past.

The nightmares start, they come too fast.

Nobody can believe it, they don't understand

I explain it to my wife, and she holds my hand.

They say you're a hero, and you should be proud.

These feelings of praise, I am not allowed

I think will day. I wish I did more

then the pain would go away, and be like before.

So I have returned home and away from the dread

the only thing that scares me is going to bed